DOCUMENT RESUME

ED 284 820	SO 018 370

AUTHOR	Clarke, Adele, Ed.; And Others
TITLE	Teaching Materials on Women, Health and Healing.
INSTITUTION	California Univ., San Francisco. Dept. of Social and Behavioral Sciences.
SPONS AGENCY	California Univ., San Francisco. School of Nursing.; Fund for the Improvement of Postsecondary Education (ED), Washington, DC.
PUB DATE	86
NOTE	151p.; For related documents, see SO 018 368-369.
AVAILABLE FROM	University of California, San Francisco, Women, Health and Healing Program, Department of Social and Behavioral Sciences, N-631-Y, San Francisco, CA 94143-0612.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	Cross Cultural Studies; *Curriculum Development; Curriculum Research; Educational Resources; *Females; Feminism; Health; *Health Education; Higher Education; *Minority Groups; *Policy Formation; Sex Role; Social Science Research; Sociocultural Patterns; *Womens Studies

ABSTRACT

Curriculum development in women's health has undergone a transformation over the past 15 years based on the availability of teaching resources. Today, the range of resources for curriculum development in women's health is more intimidating than elusive. While there has been a virtual explosion of both popular and scholarly research and writing in the many areas of women's health, there has been a dearth of materials on developing curricula in these areas. This volume is designed for use by faculty in undergraduate, graduate, and health professions and educational institutions who wish to initiate or expand their curriculum in women's health. The materials in this volume are largely edited versions of papers originally presented at three Summer Institutes on Women, Health, and Healing organized by the Women, Health and Healing Program of the University of California, San Francisco. The primary focus of these working papers on curriculum development in women's health studies is on the development and enhancement of curricula through the integration of social science perspectives on women's health, through the integration of minority women's health issues, and through addressing issues at the intersection of social science and clinical concerns. (BZ)

****

* Reproductions supplied by EDRS are the best that can be made *

* from the original document. *

****

ED284820

SO

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Adele E.
Clarke
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

TEACHING MATERIALS ON WOMEN, HEALTH AND HEALING

Edited by

Adele Clarke, Virginia Olesen and Sheryl Ruzek

Virginia Olesen, Sheryl Ruzek and Adele Clarke, Directors
Women, Health and Healing Program
Department of Social and Behavioral Sciences, N-631-Y
University of California, San Francisco, CA 94143-0612

SO018370

BEST COPY AVAILABLE

TEACHING MATERIALS ON WOMEN, HEALTH AND HEALING

EDITED BY

Adele Clarke, Virginia Olesen,
Sheryl Ruzek and Patricia Anderson

NOTE: LIST OF EDITORS ON SPINE IN ERROR.

Produced for dissemination with support from the
Fund for the Improvement of Post-Secondary Education,
U.S. Department of Education, and the Department of
Social and Behavioral Sciences and School of Nursing,
University of California, San Francisco.

© WOMEN, HEALTH AND HEALING PROGRAM
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO, 1986

UCSF Virginia Olesen, Sheryl Ruzek and Adele Clarke, Directors
Women, Health and Healing Program
Department of Social and Behavioral Sciences, N-631-Y
University of California, San Francisco, CA 94143-0612

TEACHING MATERIALS IN WOMEN, HEALTH AND HEALING

ACKNOWLEDGEMENTS

The Women, Health and Healing Program at the University of California, San Francisco, gratefully acknowledges the generous support of the Fund for the Improvement of Post-Secondary Education, U.S. Department of Education, the Department of Social and Behavioral Sciences and the School of Nurising, University of California, San Francisco, which made this volume possible.

The editors, Adele Clarke, Sheryl Ruzek and Virginia Olesen, also wish to acknowledge the many individuals and organizations whose support and encouragement over many years contributed to this work. Ellen Lewin, former Co-Director of the Women, Health and Healing Program and currently Coordinator of Women's Studies at Old Dominion College, provided energy and sustenance during the early years of effort which have culminated in this and other volumes.

We wish to thank the following organizations for permission to reprint their materials:

The Center for Research on Women, Memphis State University
The National Black Women's Health Project
Sage: A Scholarly Journal of Black Women
The Women's Health Exchange, School of Nursing, University of Illinois at Chicago

Most of all, we want to thank those who contributed their work to this volume. They were kind, thoughtful, helpful and prompt, an editor's delight.

TEACHING MATERIALS ON WOMEN, HEALTH AND HEALING

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

ABOUT THE CONTRIBUTORS

I. INTRODUCTION 1

II. TEACHING WOMEN, HEALTH AND HEALING

Section Introduction 7
Sheryl Ruzek: Women's Health Studies in the United States 8
Adele Clarke: Teaching Women's Health: Constraints, Commitments, Resources and Trade-offs 17
Eleanor Hinton Hoytt: Integrating Feminist Issues into Curricula at Historically Black Colleges 24
Denise Webster, et al.: Nursing Practice in Women's Health: A Concept Paper 32

III. INTEGRATING MINORITY WOMEN'S HEALTH INTO CURRICULA

Section Introduction 34
Sheryl Ruzek: Integrating Minority Women's Health Into the Curriculum 35
Ruth Zambrana: Fundamental Issues in Teaching About Minorities 44
Diane Lewis: Integrating Minority Women's Health into Liberal Arts Curricula 50
Ruth Zambrana: Integrating Minority Women's Health into the Professional School Curriculum 55
Karen Ito: A Case Study of Minority Curricular Integration: Asian American Women's Health 61

IV. TEACHING WOMEN'S HEALTH AS HEALTH POLICY

Section Introduction 70
Sheryl Ruzek: Teaching Women's Health with a Policy Analysis Framework 71
Roberta Spalter-Roth: Teaching Public Policy from A Feminist Perspective 73
Roberta Spalter-Roth: Framework for a Feminist Analysis of Mainstream Public Policy Research 79
Sheryl Ruzek: Teaching Sensitive Policy Issues: The Case of Abortion 84

V. RESOURCES FOR TEACHING WOMEN, HEALTH AND HEALING

A. Resources Focused on Minority Women's Health

Section Introduction 93
Basic Bibliography: Minority Women, Health & Healing 95
Sage: Selected Educational Resources on Women of Color 97
Audreye Johnson: Syllabus on African-American Women's Health Issues 99
National Black Women's Health Project: Health Fact Sheet on Black Women 108
Audio-Visual Resources on Minority Women's Health 110
Memphis State University Center for Research on Women: Women of Color and Southern Women Database Information and Search Request Forms 119

B. Resources on Women, Health and Healing

Section Introduction 125
Key Organizations and Resources in Women's Health 126
Journals in Women, Health and Healing 129
Patricia Hanson, Dorothy Battenfeld and Adele Clarke: Basic Bibliography: Rural Women's Health in the U.S. 131
Basic Bibliography: Women, Science and Health 136
Short Bibliography: Curricular Integration 139
Nursing Scan--Women's Health: Subscription Form 141
Curricular Materials on Women, Health and Healing: Information and Order Forms 142

ABOUT THE CONTRIBUTORS

ADELE CLARKE is currently a Co-Director of the Women, Health and Healing Program at the University of California, San Francisco. She has taught in women's health since 1974 and published on sterilization abuse and older women. Her current research interests are in history of reproductive science in the U.S., emergent reproductive technologies, and feminist approaches to science issues and policy.

ELEANOR HINTON HOYTT is currently Co-Director of the National Women's Studies Association Conference to be held at Spelman College in June, 1987. She has previously been Assistant Professor and Co-Director of the Africana Women's Center at Atlanta University. She teaches in the area of resources and research in women's studies and Black women's history. She also serves as Chair of the Board of Directors of the National Black Women's Health Project.

KAREN ITO is a medical and psychological anthropologist specializing in cultural interpretations of illness and culture-specific remediations. She has done fieldwork in Papua, New Guinea and in the U.S. with Polynesian Hawaiians, Asian Americans and Hispanics. She is currently on the research staff of the California Birth Defects Monitoring Group.

DIANE LEWIS is Professor of Anthropology at the University of California, Santa Cruz. She has taught both ethnic studies and women's studies courses. She is currently studying epidemiology and public health at the University of California, Berkeley, in order to pursue recent research interests in minority women's health.

VIRGINIA OLESEN was a founding Director of the Women, Health and Healing Program at the University of California, San Francisco. She has taught in this area since 1972 and her interests in women, health and healing systems lie in the areas of research and policy. With Ellen Lewin, she recently edited WOMEN, HEALTH AND HEALING: TOWARD A NEW PERSPECTIVE (Tavistock, 1985), which emphasizes health as an important domain for socio-cultural analysis.

SHERYL BURT RUZEK was a founding Director of the Women, Health and Healing Program at the University of California, San Francisco. She now teaches in the Department of Health Education at Temple University in Philadelphia. She is the author of THE WOMEN'S HEALTH MOVEMENT, FEMINIST ALTERNATIVES TO MEDICAL CONTROL and numerous articles about women's health issues. Her current research is on women and heart disease. She also edits the Health, Society and Policy Series for Temple University Press with Irving Zola of Brandeis University.

ROBERTA SPALTER-ROTH is currently Acting Director of the Women's Studies Program and Policy Center of the George Washington University. A sociologist by training, Spalter-Roth is currently involved in comparative research on husbands' and wives' living standards. Her major research interests include feminist approaches to methodology and public policy.

DENISE WEBSTER, LINDA LESLIE, BEVERLY J. McELMURRY, ALICE DAN, DIANA BIORDI, DIANE BOYER, SUSAN SWIDLER, MARCIA LIPETZ AND JOAN NEWCOMB have called themselves Members of the Chicago School of Thought in Women's Health. They have established the Women's Health Exchange in the School of Nursing, University of Illinois at Chicago. The Exchange offers a graduate nursing concentration in women's health, resource center, information and patient education and support services. They also publish NURSING SCAN--WOMEN'S HEALTH, a quarterly annotated bibliography.

RUTH ZAMBRANA is currently Assistant Professor in the School of Social Welfare at the University of California, Los Angeles. Her major interests are in maternal, child and adolescent health with a particular focus on low-income, racial-ethnic populations, women's health and access to health services, and barriers to higher educational attainment and occupational mobility among racial-ethnic women.

TEACHING MATERIALS IN WOMEN, HEALTH AND HEALING

I. INTRODUCTION:

This volume of TEACHING MATERIALS IN WOMEN, HEALTH AND HEALING is designed for use by faculty in undergraduate, graduate and health professions educational institutions who wish to initiate or expand their curriculum in women's health. While there has been a virtual explosion of both popular and scholarly research and writing in the many areas of women's health since c1970, there has been a dearth of materials on developing curricula in these areas. It is this gap in the literature which we hope our volumes will begin to fill.

The materials in this volume are largely edited versions of papers originally presented at three Summer Institutes on Women, Health and Healing organized by the Women, Health and Healing Program of the University of California, San Francisco (UCSF). We regard these as working papers on curriculum development in women's health studies. The primary focus of these materials is on the development and enhancement of curricula through the integration of social science perspectives on women's health, through the integration of minority women's health issues, and through addressing issues at the intersection of social science and clinical concerns.

This introduction first provides some background and history of the Women, Health and Healing Program at UCSF. It then describes the current state of the art and issues in curriculum development in women's health studies. Last, the various curricular materials we have produced and our rationales for their development are described.

BACKGROUND: THE WOMEN, HEALTH AND HEALING PROGRAM

The origins of this volume lie in the history of the Women, Health and Healing Program at UCSF. Two themes recurr in this history--the need for academic excellence and the need to improve the social good through the development of women's health studies. In 1973, Virginia Olesen of the Department of Social and Behavioral Sciences and Lucille Newman (an anthropologist now at Brown University) offered the first course on women's health as a way of launching women's concerns on this exclusively health sciences campus. That first course contained the seeds of the Program as it grew: an interdisciplinary curriculum, focus on the interrelations of theory and practice, concern with women's health as a socio-cultural phenomenon including but not limited to clinical concerns, and an emphasis on integrating minority women's health issues.

In addition to developing further courses on women's health, the ten years from 1973 to 1983 included several conferences focused on women's health, especially on emergent research. During these years, Sheryl Ruzek (now in the Department of Health Education at Temple University) and Ellen Lewin (now Coordinator of Women's Studies at Old Dominion College) both joined Virginia Olesen in expanding the curriculum and other activities in women's health. In 1982, six different courses in women's health were added to the permanent curriculum of the Department of Social and Behavioral Sciences. They were focused on historical, life cycle, cross-cultural, policy and occupational issues in women's health. Adele Clarke joined the Program in 1985.

This development of curriculum in women's health studies was guided by an important set of philosophical and epistemological assumptions about what is health in general and what is women's health in particular. Both were and continue to be viewed as social phenomena with historical, political, cultural, sociological and psychological as well as biological and clinical aspects. This is intentionally a broad conceptualization of health and women's health. We fundamentally assume that bringing critical, reflexive and feminist social science perspectives to bear upon health, clinical conceptions, and health care organization can be the stimulus of sorely needed social transformations in women's health--from health status to the experience of care delivery. It is through the integration of social, biological and clinical perspectives that improvement is possible. Thus we see our distinctive mission as the development of curricula in women's health which initiate and embody such integration.

In 1983, Virginia Olesen, Sheryl Ruzek and Ellen Lewin developed a grant proposal for a major nation-wide curriculum development project in women's health which gained the support of the Fund for the Improvement of Post-Secondary Education (FIPSE) of the Department of Education. The grant focused on training faculty to develop and expand curricula in women's health at all levels of post-secondary education, teaching and integrating the major courses in women's health at UCSF, preparing researchers to enter the field of women's health, and preparing curricular materials that would extend women's health education into previously underdeveloped areas such as the health issues of minority women.

These goals were accomplished through several activities, especially sponsorship and organization of three Summer Institutes on Women, Health and Healing that were held on the University of California, Berkeley campus in 1984, 1985 and 1986. These two-week long residential Institutes provided unique opportunities for faculty from all over the United States and from six other nations who had taught or were planning to teach in women's health in a post-secondary institution. About forty faculty participated in the Institute each year from community and four-year colleges, universities, and health professional schools (especially nursing but also medicine and dentistry).

The Summer Institute programs emphasized curriculum development, stimulation of research and policy activities, and extension of women's health concerns into new and emergent areas. Approximately thirty substantive topics were addressed each year. In addition to expert guest faculty presentations, participants were provided with readings and resources on each topic. A Resource Room was organized on site with audio-visual materials, syllabi, research files and literally stacks of readings which could be copied for faculty or classroom use.

It was our first hope that our Institute efforts would serve as catalysts for further activities to promote women's health studies. We believe that faculty development, curriculum development and research activities such as our Summer Institutes need to be organized on local and regional levels for varied durations and with varied foci to enhance faculty access and usefulness. We can happily report that such regional conferences have begun to occur. Second, the significant epistemological goal of our efforts has been to transcend biomedical views of women's health without losing sight of them, and to stimulate innovative teaching and clinical approaches through the integration of social science perspectives on women's health. Such expansions of perspective are also occurring in both clinical and social science settings.

RESOURCES AND CURRICULUM DEVELOPMENT IN WOMEN'S HEALTH

Curriculum development in women's health has undergone a transformation over the past fifteen years based on the availability of teaching resources. During the early 1970s, resources were few and conceptually limited at best. They ranged from what Virginia Olesen has called "over-heated and under-cited" early feminist political treatises emerging from the consumer-oriented women's health movement to quantitative studies of reproductive and other epidemiological issues to problematic medical and psychiatric specialty literatures. The only area in which there were numerically significant resources was on reproductive topics which, while important, do not constitute "women's health studies" as a field.

Today, the range of resources for curriculum development in women's health is more intimidating than elusive. Women's health topics have been addressed in print by scholars in most of the life sciences, all of the social sciences, and all of the health professions. To say that these materials are theoretically and conceptually rich is an understatement. Moreover, there is now an extensive and ever-growing popular literature on a widening range of women's health topics. It is thus within a broader context of geometrically expanded resources that we must consider curriculum development for various educational settings and purposes.

Given that it is no longer possible for individual faculty to keep abreast of women's health as a specialty (for the specialty has itself become sub-specialized), we determined that seriously organized curriculum development efforts were needed. Such efforts should not only provide up-to-date curricular materials in areas that have become conventional facets of teaching women's health, but should also explore new and emergent areas as well as the complex interrelations among the wide range of health issues which impact upon women. These were our concerns as we began our curriculum development project.

THE WOMEN, HEALTH AND HEALING PROGRAM CURRICULAR MATERIALS

In 1986, FIPSE awarded us a dissemination grant to edit this and companion volumes of materials designed to enhance curriculum development in women's health which grew out of our work on the three Summer Institutes. (See the final pages here for an order form.) Our major motivation for publishing these materials was our realization that there were many faculty who wished to initiate or expand curriculum in women's health who, for various reasons, were unable to attend our Institutes. Many such faculty were located in relatively isolated institutions and/or institutions which sorely lack resources for teaching women's health. Other faculty lacked a community of scholars who shared their interests in and commitment to curricular development in women's health.

Another motivation for this volume is to support faculty legitimacy in developing curriculum in women's health through the sheer existence of these materials. We know that the Summer Institutes provided participating faculty not only with a plethora of information but also with a new authority and confidence about the curricular validity, scholarly sophistication and intellectual importance of women's health studies.

A third motivation for publishing these materials is our recognition that a variety of pedagogical issues which have long confronted more established fields are now being encountered in women's health studies. Such issues include the development of advanced courses appropriate to local institutional populations and needs; decisions about establishing course sequences and prior coursework requirements which involve sophisticated integration schemes; and the development of strategies to address the diversity of student audiences, their varied educational levels and abilities and their varied goals in taking courses. We hope the materials in this volume will aid faculty in curriculum development tailored to and articulated with the needs of their specific educational institutions and in innovative resource organization and utilization.

The contents of this volume demonstrate our on-going concern with faculty development, curricular and resource development, the integration of minority women's health issues into curricula on women's health, and the teaching of women's health issues through health policy frameworks. Most of the articles in this volume were originally presented as papers at one of the Summer Institutes.

The Women, Health and Healing Program faculty have also compiled MINORITY WOMEN, HEALTH AND HEALING IN THE U.S.: SELECTED BIBLIOGRAPHY AND RESOURCES. This new bibliography on health issues of minority women includes sections on Black, Hispanic, Native American and Asian/Pacific women, and on comparative and reference works. Topics include overviews, history, health status, health beliefs and behavior, utilization, policy, reproduction and sexuality, maternal and child health, mental health, and minority women as providers of health care. It also has a major resources section (some of which is duplicated here). Preliminary versions of this bibliography were distributed to participants in the Summer Institutes and to others interested in women's health at various professional meetings.

Another curricular resource of related interest is our SYLLABI SET ON WOMEN, HEALTH AND HEALING: FOURTEEN COURSES. This Set includes all of the courses developed and integrated by the faculty of the Women, Health and Healing Program in the Department of Social and Behavioral Sciences at UCSF. The courses are directed at upper division undergraduate and/or graduate students predominantly in sociology, anthropology, psychology, social work, public health, nursing and women's studies. They include courses in women's health and health education, undergraduate and graduate survey courses in women's health, minority women's health, social science theory and women's health, older women's health, quantitative research in women's health, cross-cultural issues, history, comparative life cycle perspectives, general women's health policy issues and poverty and women's health policy. Additional syllabi in women's health can be found in Sue V. Rosser's book, TEACHING SCIENCE AND HEALTH FROM A FEMINIST PERSPECTIVE: A

PRACTICAL GUIDE, 1986 (Pergamon Press, Inc., Maxwell House, Fairview Park, Elmsford, New York 10523).

We sincerely hope that you find the materials in this and our other volumes valuable in your efforts to develop women's health studies curriculum. Thank you for your support.

II. TEACHING WOMEN, HEALTH AND HEALING

SECTION INTRODUCTION

This section begins with an important overview of the emergence of women's health studies by Sheryl Ruzek. Her article provides entree into women's health studies for newcomers and stimulates fresh reconceptualizations of the field among those who have participated in it. Future directions of women's health studies are also examined.

Adele Clarke's paper focuses on faculty decision-making and tradeoffs in developing curriculum for and teaching an introductory undergraduate survey course on women's health. She offers both a conceptual framework and concrete strategies for curricular design and class discussion.

Eleanor Hinton Hoytt's paper is an overview of the development of Black women's studies and innovative strategies for curricular integration recently implemented at historically Black colleges and universities. Black feminists have forged new models for integrating scholarly and community concerns which can serve as models for faculty and curricular development in women's health.

The Women's Health Exchange group from the School of Nursing at the University of Illinois at Chicago offers a conceptual paper on developing a new clinical framework for a women's health care practice. We can see in their premises of a women's health practice the creative synthesis of clinical, social science, feminist and ethical perspectives.

Together these papers raise practical and theoretical issues, provide a sense of the very varied settings in which women's health courses are offered, and contrast the concerns of faculty teaching in different situations with different constraints, opportunities and resources.

WOMEN'S HEALTH STUDIES IN THE UNITED STATES

Sheryl Ruzek

Research, scholarship and teaching in women's health grew rapidly in the academy in response to the interest generated by the contemporary wave of feminism. Research on many women's health issues had, of course, been carried out in the past. But the research prior to the late 1960s was done mostly by men, or by women who were trained in male dominated and male oriented academic and clinical fields. Many issues related to women's health were ignored, trivialized, or simply not considered. Over the past fifteen years, new perspectives emerged, perspectives which go beyond the traditional bio-medical or clinical perspectives with which we are all familiar. Here I shall briefly contrast these familiar approaches with what we might appropriately term "women's health studies" to emphasize the underlying framework of women's studies which informs these new perspectives and approaches.

FEMINIST PERSPECTIVES IN WOMEN'S HEALTH STUDIES

At the center of women's health studies is a feminist perspective, but feminists themselves do not always agree on definitions of feminism. In the broadest sense, feminism can be defined as a world view which places women at the center of analysis and social action. Persons who identify themselves as feminists have an ideological commitment to fostering the well-being of women both as individuals and as a social group. But this commitment means quite different things to different people. (Ruzek 1986) In western industrialized countries, those who view themselves primarily as liberal feminists, radical feminists, and socialist or Marxist feminists assign very different meanings and actions to this commitment. Thus, as Elizabeth Fee (1983) points out, liberal feminists see feminism as a social movement designed to ensure women equal opportunities in all spheres of life. Radical feminists see the movement as involving more fundamental reordering of social life and have played central roles in the development of alternative services by and for women. Socialist or Marxist feminists focus on raising awareness of how the dynamics of industrial capitalism make securing women's health problematic.

In women's health studies in colleges, universities and health professions training schools, these underlying commitments take on a variety of forms. What is shared across perspectives is a concern for the quality of health and medical care and women's own subjective experience of health. In contrast to purely bio-medically oriented "health and hygiene" or obstetrics, gynecology and maternal health courses, women's health studies courses tend to incorporate or even emphasize the view that women's health must be viewed in a broad socio-cultural framework. That is, women's experience of health and illness is conceptualized as having social, political, econonmic, psychological and cultural dimensions. Health is more than the absence of disease or the functioning of organ-systems. Central to this perspective is an understanding of how women's place in the larger social system affects the production, consumption, and experience of health and illness and the provision and receipt of health and medical care in the family, the community, and in formal health care systems. Of particular importance is the emphasis placed on understanding women's own subjective experience of health and health caring by allowing women to speak about these matters in their own voices.

These themes, shift in focus, and attention to women's own voices are what differentiate women's health studies from traditional perspectives. Perhaps the easiest way to contrast these approaches is to consider the tone and content of the Boston Women's Health Book Collective's (1984) Our Bodies, Ourselves, with virtually any textbook used in high school or college health and hygiene courses in the 1950s or 1960s. What we define as important has shifted quite dramatically. What we now hear are women's own definitions of issues, not simply the "facts" as viewed by medical-professional "experts."

The differences also become clearer when we consider what is "covered" in different types of settings. If we are discussing contraceptives, for example, the emphasis is different in different settings. In conventional clinically oriented health courses aimed at undergraduates, for example, "information" is given about the various types available, about the "failure rates", about how they are "correctly used" and so forth. In contrast, courses given from a women's health studies perspective are focused not only on how you actually use contraceptives, but how women feel when they use them, what problems they have with health providers or sexual partners. In such courses attention is also directed towards the role that contraceptive drugs, devices, and practices play in the social control of women. Distinctions are often made between population control, family planning, and birth control.

We also see a shift in definitions of who has the legitimate right to define what is going on, what is important, what is safe, what is dangerous, what is an acceptable risk. In the late 1960s and early 70s only certain "properly certified experts," i.e. obstetrician-gynecologists were defined as having expertise worth considering. Today, lay groups, nurses, midwives, social scientists and many others are viewed by the public as having legitimate knowledge.

THE DEVELOPMENT OF WOMEN'S HEALTH STUDIES IN THE ACADEMY

The growth of interest in this country in women's health issues and health in general is an interesting case study of how science is affected by extrascientific factors. While many historians of science--especially health and medical science--have emphasized the progress of science only by considering factors internal to science, here we see how different branches of science, the natural sciences and the social sciences, indeed have been affected, and I believe profoundly affected, by extra-scientific factors. Specifically we see how social movements have redefined many aspects of what is "important."

Because of increased public interest in women's health and the growth of community based feminist health courses and activities, (see e.g. Boston Women's Health Book Collective 1984; Federation of Feminist Women's Health Center, 1981; Ruzek 1978, 1986) it is not surprising that there was pressure to have similar courses in the academy. The emergence of women's studies in general provided a framework and rationale for both adding and revising courses.

The first type of course that entered the academy was what can be termed a "body course," modeled after self-help courses offered in the community. Historically, these are the hardest to track and trace, because they were often taught at the margins of the academy by temporary, part-time faculty in women's studies programs or under the sponsorships of a faculty member who wouldn't, couldn't, or was afraid to teach such a course. Some were in fact student-taught and carried group study or independent study credit under the sponsorship of a sympathetic faculty member. Because they often were carried out under special study titles, and only entered the college catalogue later, historians will have to rely on archival material and oral history to date their "beginnings" accurately.

The type of course that was offered earliest in many institutions focused on reproductive health and relied heavily on literature produced in the lay feminist world. Early editions of Our Bodies, Ourselves (1976) and Ehrenreich and English's pamphlets, Witches, Midwives and Nurses (1972) and Complaints and Disorders (1973), constituted the "core curriculum". Such courses might be characterized as composed of equal parts of personal experience, politics and the mechanics of moving body parts. Over time these courses expanded and developed within the academy into new forms. Some are institutionalized within women's studies programs and others are located in other departments such as physical education, health education, home economics, and nursing. Many still use materials such as Our Bodies, Ourselves, but there are new materials produced not only by physicians but by scientists, health writers and others that explain not only how the body works but have more sociocultural, behavioral, and political perspectives. An excellent example of this type of course syllabus is one developed by Adele Clarke (1986) for the Women's Studies Program, Sonoma State University. Others are included in Rosser (1986) and in Women's Studies Quarterly.

A second group of courses that emerged in colleges and universities are grounded more specifically in the social and behavioral sciences. Courses developed at the University of California, San Francisco, represent this model (Olesen, Ruzek, Clarke 1986). Such courses take a variety of directions. Typically they focus on feminist research and scholarship which address women's subjective experiences of health using qualitative research methods, sex differences in health status and health service utilization relying on demographic and quantitative data, and socio-political, economic and historical analyses of health and illness. Many move beyond reproductive health issues into the entire array of health topics. Some are taught in women's studies departments or programs, but many are located in sociology, history, psychology or interdisciplinary social sciences. These courses are well described by Rosser (1986).

The third major type of courses are biologically or clinically oriented courses which emerged in the basic sciences and health professions training schools such as nursing, medicine, and public health. Syllabi for these courses also appear in Rosser (1986). I believe that the courses offered in health professions training schools are the least well-alligned with women's studies programs. That has affected our perception of what is actually going on in relation to the development of "the new scholarship on women," especially in the field of health.

My own perception of what is being offered is based on my longstanding albeit less than systematic observation of and participation in developing such courses, the syllabi Sue Rosser collected for her book, Teaching Science and Health from a Feminist Perspective, and the more than 100 syllabi provided by participants during the three Women, Health and Healing Summer Institutes. First I shall comment on Rosser's survey and then discuss factors which we need to consider to assess what is being taught by whom where in the academy.

Rosser sent leters to all women's studies departments and programs listed in the fall 1984 Women's Studies Quarterly. She requested syllabi on courses being taught focusing on women's health and science. Rosser only received an 8% response from the 434 institutions she contacted. Given how poorly funded women's studies programs are, how time consuming answering such requests can be, and the time-frame for the survey, such a low response rate is understandable. All of the undergraduate course syllabi Rosser received are included; the syllabi of courses developed at the University of California at San Francisco were not included because they were all graduate level courses.

Looking at the syllabi in Teaching Science and Health From a Feminist Perspective, it is interesting to analyze the departments in which courses are offered and/or in which credit is given. The underlying questions which we would like to explore eventually are: 1) Who has the power to define something as part of a field and a "legitimate" subject for which academic credit for study will be given? 2) What parts of the university allocate scarce resources such as faculty time, classroom space, and curricular competition for women's health studies? The syllabi Rosser received can only be classified by where they were offered for credit. They are offered 1) only for women's studies credit, 2) only for credit in a department other than women's studies, and 3) cross-listed with women's studies and another department. From the data we can not really answer the underlying questions because to do so we would need to know a great deal about the structure of each institution. So, for example, the patterns of credit reflect larger structural factors such as whether or not there is even a women's studies structure which could offer credit and allocate resources. Nonetheless, the patterns are interesting and suggest that the ongoing debate in women's studies over "mainstreaming" versus "ghettoizing" may be a "non-issue" for the subspeciality of women's health studies which is taking root in many different arenas within the academy.

Of the syllabi Rosser received, only nine courses were offered only by women's studies. This was surprising at first glance, but on reflection it helped to "explain" some of our experience in screening applicants for the Women's Health and Healing Institute. We initially expected to receive a large proportion of applications from women's studies faculty. We had very few and were somewhat puzzled. In light of Rosser's experience and our own of going to women's studies meetings and discovering that we folks "doing health" were seen as somewhat "peculiar" we suspect that in fact, women's studies per se is the base for a relatively small proportion of the post-secondary educational activities in women's health studies. Just how small a proportion of the "total" this is of course remains a research question.

Turning to courses offered only in departments outside of women's studies, six syllabi were received, four of which were taught in biology departments. These syllabi include topics that many of us, ten years ago, would have never thought about --particularly gender issues in the methodology of natural science. The other two, listed only in health education and public affairs are more like those in women's studies and the social sciences.

The most typical pattern was cross-listing, with women's studies and another department - six with natural sciences, nine with history, eight with health professions, one with education, and two with other social sciences.

We should not make too much about the actual numbers here because Rosser's sample is small and represents a poor return rate. Our experience also suggests that there is an enormous amount of teaching of women's health studies in health profession schools, especially nursing. Rosser's data do not reveal this, and we believe that this is due in part to her choice of women's studies coordinators as the primary source of data.

Health profession schools often are both intellectually and physically separated from women's studies, sometimes even on separate campuses. In addition, feminists involved in women's studies sometimes use nursing as an example of a prototypically subordinate and oppressed female ghetto. Individual nurses, like housewives, too often feel personally denigrated by such criticism and the emphasis on moving women into medicine rather than looking at the significant contributions of women in nursing. In such an atmosphere, important linkages between women's studies and nursing and allied health fields were not adequately developed. Given this, women's studies coordinators may simply be unaware of the extent to which women's health studies have grown outside of arts and sciences.

CONTENT AND STRUCTURE OF WOMEN'S HEALTH STUDIES

Reviewing syllabi of women's health studies, one is struck by the multi-disciplinary nature of such endeavors. One of the difficulties in teaching women's health studies is that it is inherently multidisciplinary. Even those of us who teach in a single discipline recognize that we have to move beyond our own disciplines to deal with a wide array of issues. A typical way to manage this is to get guest lecturers for courses. When carried too far, we run into problems of quality control, problems of finding people and rewarding them, and running the risk of having students fail to develop a coherent view of women's health issues. It leads towards a "laundry list" approach to women's health rather than to a conceptually coherent framework. I raise this issue with some discomfort because one of the problems is that we really have not developed an adequate conceptual framework. I also have reservations about providing students a superficial introduction to an array of topics without having or providing theoretically, methodologically and empirically solid backing which is so essential to good scholarship. I am more and more convinced that students really must be firmly entrenched in a specific discipline to produce good work.

When we cut across disciplines, it is much harder than early women's studies advocates anticipated. We have to deal with both qualitative and quantitative research methods and other forms of scholarship. We also must grapple with where we publish our work. Journals such as Women and Health are multidisciplinary as are many of the women's studies journals, but this approach contradicts the academic trend towards narrower and narrower specialization. What may actually be emerging is a "two-tier" system of scholarship. In this system, scholars publish articles in specialty journals such as The New England Journal of Medicine, The Journal of Health and Social Behavior, or some other more established disciplinary journal and then write another article for Women and Health in language which is more accessible to students. Such journals then do not necessarily publish scientific findings for the first time, but publish articles which synthesize findings in relation to other bodies of literature. It will be interesting to study the fate of these multi-disciplinary journals over time to see whether or not such publications can be sustained in academic settings.

The content of our scholarship is changing in other ways as well. Our first task was to convince the academy that it was worth talking about women qua women as a group. So we talked about sex differences, sex discrimination, gender roles and women's health problems sometimes in very global ways. In doing that, it was all too easy to fail to differentiate which women we were talking about. The complexities of race, class, ethnicity, and religion were submerged by the focus on gender. Partly it was a political necessity to emphasize commonalities and downplay differences, but sometimes differences were simply not recognized or understood. Now that women's studies in general and women's health studies in particular appear to be institutionized in the academy, it is essential for us to look more closely at the differences among and between women and do some serious comparative research in many areas. Within our program we have tried to deal with diversity and differences by considering the different experience of racial minorities, ethnic minorities and cultural minorities. We use the term cultural minorities quite deliberately as part of a strategy of legitimation. It is a linguistic tool which allows one to discuss virtually anything difficult to talk about in one's own institution, be it sexual orientation, religion, or anything else which is "different" from the dominant culture of one's institution. This language is also useful for "neutralizing" topics in order to survive unfriendly review committees and other obstacle courses.

We feel that it is particularly important to emphasize how the dynamics of race and class in particular interact with gender to produce health and illness and responses to health status among different groups of women. We believe that this is so important that by the end of the term every student should, when talking about women, be able to conceptualize whether or not they are referring to "all" women or to specific groups of women under specific conditions.

The other critical task that faces us now is developing and elaborating a conceptual framework or frameworks for dealing with women's health issues. This needs to emerge between and across disciplines, but it first perhaps needs to be articulated more clearly within specific disciplines. I believe that this is more advanced in history than in other disciplines. In history we see an emerging body of scholarship which moves in a somewhat orderly way from a crude rethinking of the very topics which warrant investigation to some very creative theory building and even hypothesis-testing. These trends and developments stand out very clearly in Judith Walzer Leavitt's Women and Health in America: Historical Essays (1984). While Walzer's work is specific to history, she in fact addresses many themes and issues which can be and are investigated in the present by other scholars - women's roles as health care providers, the meaning of health and illness as part of larger gender roles, and the centrality of health and healing to women's life experience.

TOWARDS THE FUTURE

To maintain the momentum of the new scholarship on women in women's health studies, we must proceed along two distinct lines. These lines must be viewed as complimentary rather than as in competition or contradiction to each other. First, the emphasis on multi-disciplinary exchange must be preserved and enhanced. There is much to be gained by talking and listening to each other across disciplines. To develop teaching strategies and a political base for encouraging such teaching is essential.

At the same time, we need to pay increasing attention to ways in which theory building is best accomplished--perhaps within "disciplinary groups" rather than just within single disciplines. The very nature of theory building demands solid grounding in at least one discipline--but even more narrowly with a particular school of thought or paradigm which operates within a discipline. As women's health studies develop further within the academy, more of this narrowly focused work will have to take place. Specialization is indeed a fact of scholarly life. In women's health studies, our future rests on our ability to juggle and manage the tension between specialization and generalization --our ability to train ourselves and our students to master some specialized areas of knowledge without withdrawing into the position that we can only express an opinion on such matters. If we fall prey to this viewpoint we put ourselves at risk of being manipulated by experts whose interests may very well not be our own. If we accept an exclusively technical definition of science and ignore the social nature of scientific endeavors, we essentially relinquish both our rights and responsibilities for seeing that health sciences serve real human needs. I believe that we will fail at our most central task if we produce only technical specialists in women's health. For while technical expertise in narrow areas is necessary, we desperately need people who can competently and thoughtfully evaluate the findings, priorities, and interests of a wide array of specialists. As western, industrialized nations attempt to meet the growing crisis of the welfare state and the social burden that high technology medicine has become, we are certain to make major changes in the organization of health and medical care. It is imperative that women play key roles in the renegotiation of national health priorities, including research priorities. The kind of women's health studies that have developed in the United States provide a framework within which women can and must be trained to take leadership roles at all levels--from clinical practice to scientific investigation and the development of health policy. There is yet much work for us to do.

References

Boston Women's Health Book Collective (1976) Our Bodies, Ourselves--A Book By and for Women. 2nd ed. rev. New York: Simon and Schuster.

Boston Women's Health Book Collective (1984) The New Our Bodies, Ourselves. New York: Simon and Schuster.

Clarke, Adele (1986) "Feminist Perspectives on Women's Health," in V. Olesen, S. Ruzek, A. Clarke, Eds., "Syllabi Set on Women, Health and Healing: 15 Courses." San Francisco: Women, Health and Healing Project, University of California.

Federation of Feminist Women's Health Centers (1981) A New View of a Woman's Body. A Fully Illustrated Guide. New York: Simon and Schuster.

Ehrenreich, Barbara and Deirdre English. (1972) Witches, Midwives, and Nurses: A History of Women Healers. Old Westbury, N.Y.: The Feminist Press.

Ehrenreich, Barbara and Deirdre English (1983) Complaints and Disorders: The Sexual Politics of Sickness. Old Westbury, N.Y.: The Feminist Press.

Fee, Elizabeth (1983) "Women and Health Care: A Comparison of Theories," in Elizabeth Fee, Ed., Women and Health, The Politics of Health in Medicine. Farmingdale, N.Y.: Baywood Publishing Company.

Leavitt, Judith Walzer, Ed. (1984) Women and Health in America. Madison: University of Wisconsin Press.

Rosser, Sue V. (1986) Teaching Science and Health from a Feminist Perspective. New York: Pergamon Press.

Ruzek, Sheryl (1986) "Feminist Visions of Health: An International Perspective," in Juliet Mitchell and Ann Oakley, Eds., What is Feminism? London: Basil Blackwell.

Ruzek, Sheryl Burt, (1978) The Women's Health Movement, Feminist Alternatives to Medical Control. New York: Praeger.

TEACHING WOMEN'S HEALTH: CONSTRAINTS, COMMITMENTS, RESOURCES AND TRADEOFFS

Adele Clarke

My goal in this paper is to provide a working conceptual vocabulary with which faculty in women's health (and other fields) can frame a variety of pedagogical, political and practical issues we confront in teaching. I begin by introducing this vocabulary and theoretical framework and then illustrate it through a case study of teaching an introductory undergraduate women's health survey course at Sonoma State University where I was Coordinator of the Women's Studies Program (1978-1981).

There are a variety of audiences of teaching, consumers of the courses, and particular constraints, opportunities and resources in any given teaching situation. Faculty also bring a variety of commitments to that situation in terms of feminism, approaches to teaching and so on. These factors are highly interactive. In managing them in order to get the job done, we must negotiate these factors and make tradeoffs among them.

By tradeoffs I mean forced decisions we must make when we cannot have our cake and eat it too--when the constraints in our teaching situations force us to make difficult choices. We are commonly put in the position of having to choose among several options each of which has consequences for later options. For example, many of us are given the "choice" of teaching a semester-long introductory course in contemporary women's health or not teaching such a course at all. A two-semester sequence is often inappropriate given various institutional constraints. In such a course, one can either aim at developing theoretical sophistication or one can introduce a wide range of issues. One cannot do both in one semester. Decisions flow from prior decisions.

I am arguing here that tradeoffs are at the heart of decision-making in teaching (not just in women's health) and that they characterize our processes as faculty from course selection and design stages to classroom interaction to final grading. I want to name this process and tease out some of its components. I also hope to achieve a joint acknowledgement of both the routine nature and difficult aspects of tradeoffs in teaching and normalize this process especially for begining teachers.

Teaching can be a rather lonely experience and is a trial and error effort in each course, especially if we attempt to develop new curricula and integrate new materials. The major problem is that we too often attribute our successes to chance and our errors to personal failure. While this tendency does abate over the years, it does not seem to disappear. Understanding the players and the other components of the teaching game may alleviate some of the anxieties. Understanding tradeoffs as decisions forced by circumstances can allow us to see and come to grips more explicitly with the structural constraints built into our teaching situations. Metaphorically, we can rearrange the furniture even if we cannot replace it or redesign the building.

Let me discuss and illustrate the components of my framework more specifically. The multiple audiences of my courses at Sonoma State included other local women's studies faculty and students, campus friends and enemies, administrative and evaluative groups, and other faculty in women's health with whom I was in contact through professional networks. The direct consumers of my teaching were the students in the courses and, indirectly, all the others with whom they discussed women's health issues. I was also a component in all my hats--as scholar, feminist, teacher, activist, colleague and so on.

The next two components are the constraints and opportunities in one's particular teaching situation. These are highly local phenomena. I taught women's health in a particular Women's Studies Program, with its own history, at a particular state university with its own history. These confronted me simultaneously with specific constraints and opportunities or structural weaknesses and strengths which I had to negotiate.

The last major component is resources. These can be local, national and more and more in women's health even international. They can range from guest speakers from a local women's shelter or feminist health center to the latest analysis of global issues in women's health. Professional networks which have been developing rapidly in women's health are also major resources. Today the range of resources for teaching women's health are more intimidating than elusive.

To summarize thus far, the major components which we must negotiate are multiple audiences, direct and indirect consumers, particular local constraints and opportunities, and a wide variety of resources. How we negotiate these is by trading-off among them. The concept of tradeoffs clarifies what we do in our decisions; it puts our priorities into bold relief. Tradeoffs reflect very deeply our personal, political and theoretical analyses of the teaching situation and our commitments in that situation. This is why it is important to understand them.

Tradeoffs in an Introductory Survey Course:

The particular constraints and opportunities I dealt with are best framed through a description of the Women's Studies Program at Sonoma State University. Sonoma is a small (5000+) mostly liberal arts becoming management/computing-centered campus about 70 miles north of San Francisco. The average age of the students is 27, and they have more children per student than any other campus in the system. It is a very white campus. Most students are the first in their families to attend college. Many have little preparation for college-level much less scholarly work and even less confidence in their abilities to do well in school.

The Women's Studies Program was begun in 1971/2 as an independent entity with its own faculty. The faculty allocation has been 1.0 for years. It has been a fairly progressive program, with a high degree of student involvement at all levels, including program administration, and a participatory atmosphere. The Program has survived the vicissitudes of feminism as well as a number of rather vicious attempts by the administration to terminate it. We had a wonderful "Decade Plus Reunion" in 1983 with well over a hundred former students and faculty.

Carefully supervised student-taught courses were at the heart of student involvement. Given the small faculty allocation and the limited numbers of faculty offering courses with explicit content on women elsewhere on campus, student-taught courses have given breadth and the capacity for innovation to a constrained program. Indeed, the first course on women's health was student-taught, both titled and based on OUR BODIES OUR SELVES.

Deriving from the feminism of the Program were the basic issues which all courses offered under the Women's Studies rubric were required to attend to in some way. These were nicknamed "The Big Seven:" issues of gender, race, class, age, sexual preference, physicality (appearance and disability) and motherhood. Thus in a course on women's health, one would directly address gender and health, race and health, class and health, and so on, in the syllabus. Not listed in the Big Seven, but deeply assumed was that all Women's Studies courses aimed at empowering the students in their personal, academic and political lives.

This then was the situational heritage in which I began teaching women's health--an introductory survey course meeting four hours per week for one semester. Few of the students would have had any women's studies courses, though some would be very sophisticated. Most would know nothing about basic biology, anatomy or physiology, though some pre-med students and several nurses might enroll. Some would know nothing about women's health issues, while others would have extensive knowledge--often more intimate knowledge than they would like.

The course was usually well-enrolled with about 40 students. Enrollments were an on-going audience problem for women's studies vis-a-vis the administration. It was therefore routinely in my mind that it would be ideal if some of the students subsequently took other women's studies courses. It was a structural dimension of my situation that I was expected to promote Women's Studies through women's health.

Starting from there, the rest was up to me. Previous teaching experience with similar students around gender issues and around health had shocked me with the urgency of many students' needs. Needs for basic understanding of biology.

Needs for intellectual tools with which to learn. Needs for talking about their experiences in a supportive atmosphere so they could learn from them. Needs for coping with particular current and future health problems. How then to meet their needs, my goals, the Program's agenda, the expectations of all the audiences I listed earlier? What did I want to accomplish most?

After a couple of unsuccessful attempts, my first major tradeoff was to aim at developing certain core concepts over a broad range of issues rather than futilely try to teach comparative theoretical approaches to a few issues. I made this tradeoff (and no where near as consciously as this sounds) for two reasons. First, not only did students lack any theoretical background (much less share one) but also the word "theory" itself froze them in their tracks and rendered them mute. Subsequently another teacher named a course "Feminist Theories of the Family." The students objected to the word "theory" and the administration at that time was uncomfortable with the word "feminist." (I did not like "the family" in the singular!)

The second reason I made this tradeoff was the potentially concrete nature of women's health as a course for this population of students at this institution. At an extreme end of the continuum, but well within the realm of the possible, such a course might make a difference between someone's life or death--and certainly health and illness. These students were not going to get basic health information anywhere else. Enabling them to cope well with their own or a friend's breast cancer and mastectomy ultimately seemed more important to me than their capacity to articulate theoretical analyses. Anyone interested in theory I could individually guide along. And I did.

The basic concepts I aimed to develop were the Big Seven I mentioned earlier: gender and sexism, race and racism, class and classism, lesbianism and homophobia, age and ageism, the politics of appearance and ability/disability, and the politics of motherhood. All of these were handled in three ways:

1) basic definitions emphasizing the social and institutional as well as individual nature of the problems;
2) as full class sessions or segments of sessions; and
3) as they were manifest across the wide variety of issues we addressed in the course.

For example, we would spend a week on race, class and health--and do so early in the course. Later, when focusing on pregnancy and childbirth, infant mortality issues made conceptual sense in terms of its race and class dimensions. The same was true for sterilization abuse. Disability issues were discussed on their own, in relation to appearance, in terms of reproductive rights (their absence for many disabled people) and in terms of emerging reproductive technologies. My approach here combined both autonomous conceptual work with mainstreamed or integrated substantive development of those concepts.

But overall, I did not always feel satisfied with this tradeoff. I looked at someone's syllabus from a more intellectually sophisticated school and felt I was not being theoretical enough. When the administration was reviewing the Program using all course syllabi, I worried that it was not scholarly enough. When the faculty in Nursing looked, I worried that it was not clinical enough. And so on and on. This is the inherent nature of tradeoffs. They are decisions we have made and must live with; we may never be fully content with them. Yet they may be the very best choices for a given situation.

My second major tradeoff reflected the first. I structured my teaching of each women's health issue along three dimensions:

1) the biology of the particular process;
2) particular health problems and treatments surrounding it;
3) the politics of the issue--which in the feminist tradition included personal aspects.

I could not assume that my students knew--or really understood even basic anatomy or physiology. I therefore discussed these in a very matter of fact mechanical fashion and operated on the principle of redundancy: every time I talked about the female reproductive system, I drew it on the board. This too helped demystify biology.

Women's health problems and treatment alternatives were similarly handled. I would discuss how the medical and political aspects revealed conflicting theories and approaches, and how sexism, racism, classism and so on were manifested around the particular issue. The students ended up with a firm basic grasp of the issue and at least some familiarity with the debates and available resources.

A third tradeoff was spending class time on what we called individual "Health Herstories" rather than going into more depth on specific issues. These were 10-15 minute presentations by each class member about her life in terms of health issues from birth to the present. [An outline of how to structure Health Herstories appears in my syllabus for WOMS 325 in our SYLLABI SET ON WOMEN, HEALTH AND HEALING.]

I developed Health Herstories as a structured part of the course out of desperation. In both my women's health and other health courses, in the midst of a lecture a student would raise her hand and go off on a bad doctor story, a bad this story, some very-important-to-her-but-tangential-to-my-current-goal story. This was incredibly disruptive to me and the class and yet reflected a real need on students' parts to understand some health event and come to terms with it both intellectually and in terms of personal feelings. Some means of meeting such needs had to be "built in" to the course.

From our introduction of it on the first day of class, the Health Herstory component let students know that they would have an opportunity to tell their stories, that their experiences reflected those of many women, and that we can survive amazing situations. I found that by using this structure students offered their experiences illustratively to my lecture/discussion of the moment rather than in a tangential and disruptive manner. I also was able to refer back to students' experiences illustratively. It thus "worked" well for all of us. The "costs" of this tradeoff lay in class time. But with a large class, I broke students into smaller, semester-long groups for these herstories, and allowed a maximum of 15 minutes per week for them. The tradeoff was worth it, though I did not always listen patiently.

On occasion there were personal health emergencies that needed immediate management. In one exceptional semester I had a small class of 12. We had--that I know of--three abortions, one case of PID from IUD use (happily two weeks after we discussed this), one premature menopause at age 32 from contraceptive sterilization, one miscarriage, and one student had to drop the course due to endometriosis. We also had what looked to be two serious depressions and a general hysteria about "eating disorders and stress management."

Not all these issues were dealt with in class, but many were. And most students mentioned sharing information with friends both generally and in crisis. Some crises became, in the feminist tradition, the basis for research. The woman who had the miscarriage did a lovely review of the popular literature available on it specifying what was not discussed that should have been--establishing criteria for a critical review based on both the course framework (found in the syllabus) and on her own experience. So the personal can be transformed not only into the political but into the intellectual as well. Empowerment can be simultaneously personal, political and intellectual.

CONCLUSIONS:

Clearly my fundamental commitments in teaching this introductory, one-semester women's health survey course were twofold:

1) to the consumers--students and their concrete needs;
2) to a feminist politic in its broad sense--the issues we called the "Big Seven."

In making my particular tradeoffs, these commitments had priority. I handled the other audiences as best I could given my primary commitments in that particular teaching situation. For example, I did a very elaborate and explanatory syllabus that as a document would "satisfy" administrative eyes. The readings were extensive (the students said exhaustive). The exams were ambitious essays, and no A's or B's were given without research of some sort. This was what I term a friendly rigor.

The constraints in that situation were that I could not teach advanced courses on women's health except on very rare occasion. Moreover, the survey course which should be two semesters was compressed into one. Even deleting explicit comparative theoretical perspectives, this was not enough and I ended up feeling it was superficial on certain issues. The opportunties were a real freedom to teach wonderful and excited students about fundamental issues in their lives--to make a postive difference in women's lives at many levels.

Teaching can be theoretically and metaphorically viewed as a balancing or negotiating act where we must simultaneously handle audiences, consumers, constraints, opportunties and resources. We manage these by making tradeoffs based on our commitments within a given situation at a specific historical moment. The moral of this story is that we cannot please all of the people all of the time--including ourselves--but we can know what we are doing--and why. This can make an important difference.

INTEGRATING FEMINIST ISSUES INTO CURRICULA AT HISTORICALLY BLACK COLLEGES

Eleanor Hinton Hoytt

Why Black women's studies and what difference does it make? These large questions are recurring ones among faculty, administrators, students, supporters and detractors alike. They are wrought with political significance and pedagogical implications. And they are questions which need to be addressed prior to discussing the approaches and problems of integrating feminist perspectives into the curriculum at historically Black colleges.

Some of the most significant changes in higher education during the past two decades have emerged from Black studies and women's studies. These two developments called for a reconceptualization of history. Black and women's studies scholars generated data, developed courses and theories, and defined new social realities for Blacks and women.

Black studies concentrated primarily on Black men, while white women were the focus in women's studies. In response to these racial and gender biases, Black women's studies emerged. The most noteworthy developments in Black women's studies have come from a relatively small number of Black women scholars who have spent the past decade studying and researching Black women and now, more recently, writing about Black women.

This paper first addresses the question of "Why Black women's studies?" and calls attention to the work of individuals, organizations, and institutions engaged in research and scholarship on Black women. Then the topic integrating feminist perspectives at historically Black colleges is considered through a focus on a two-year faculty development project at Atlanta University.

The argument for Black women's studies begins compensatorily as we come to terms with invisibility--the absence of or minimal attention given to Black women in research on race and sex. In Black studies and women's studies alike, Black women are too often footnotes to "all the Blacks who are men and all the women who are white" (Hull, Scott and Smith, 1982). The exceptions to these omissions have been extraordinary women such as Sojourner Truth, Harriet Tubman and Ida B. Wells Barnett, who just happen to be women.

The argument for Black women's studies continues as we cite the distorted ways in which history has made us visible. The misunderstandings and misinterpretations in these mythological histories define Black women in multiple roles, yet simultaneously define the monolithic "Black woman." This further compounds our problems. The argument progresses with a declaration of the need for the creation of knowledge by, about and for Black women. That need is dramatized by the publication of three major documentary histories on Black women: Gerda Lerner's BLACK WOMEN IN WHITE AMERICA which ushered in Black women's voices in 1972; Bert Loewenberg and Ruth Bogin's BLACK WOMEN IN 19TH CENTURY AMERICAN LIFE (1976) which brought us the words of 19th century Black women in their struggles for education and community and racial uplift; and the latest documentary, WE ARE YOUR SISTERS, by Dorothy Sterling (1984). What buttresses the argument for Black women's studies is that these works document the voices and thoughts of Black women and document the fact that the historical record exists but has been lying unused and neglected.

Once we have revealed the distortions and omissions of the realities of Black women's lives, and once the creation of new knowledge has filled some of the gaps, the Black feminist scholar begins the struggle of "discovery." Yet this is not merely a task of rendering Black women visible. Although we cannot hope to reconstitute ourselves in all the absences and ill-conceived presences, the Black feminist writer does attempt to "tell her own story" and to define her own social realities. In arguing that most contemporary feminist theory does not adequately account for the experiences of Black women, the Black feminist scholar attempts to theorize about the interconnections of gender, race, and class as they occur in our lives, thus providing our own stage for expression and action.

Gloria Wade-Gayles (1984), a Black woman scholar, suggests in her conceptual framework for understanding the anomalous position of Black women that "there are three major circles of reality in American society:"

> In one circle, white people, mainly males, experience influence and power. Far removed from it is the second circle, a narrow space in which Black people, regardless of sex, experience uncertainty and powerlessness. And in this narrow space, often hidden but no less present and real, is a small dark enclosure for Black women only. It is in this enclosure that Black women experience...the unique marks of Black womanhood.

It is within this unique status of Black womanhood that is distinct from Black men and distinct from white people that a Black feminist approach can illuminate the female experience.

Black women's studies had its beginings in 1972 when Alice Walker developed a course on Black women writers at Wellesley College. By 1974, 45 courses related to Black women, out of the 4,658 courses listed in WHO'S WHO AND WHERE IN WOMEN'S STUDIES (1974). Of those 45 courses, 16 were survey courses, 10 focused on literature, and 4 on history, following the pattern that dominated in women's studies and Black studies. None of those courses used the word feminist or Black feminist in the title. Approximately nine Black colleges offered women's studies courses at that time.

Since 1974, there is evidence that Black women's studies is developing through faculty and curriculum development projects, institutes, women's centers, and the output of a small core of scholarly publications emanating from a small community of Black women writers. In 1984, ten Black women's studies projects were listed in SAGE: A SCHOLARLY JOURNAL OF BLACK WOMEN, including Atlanta University and the Spelman College Projects with which I have been associated. Although there was no indication of the number of colleges or faculty involved in these ten projects, we can assume that the numbers have at least doubled since the 1974 count of 45 courses.

One attempt to confront the challenge of addressing the needs and concerns of Black women in higher education was made at Atlanta University in 1983 with the establishment of the Africana Women's Center. The Center's primary goal has been to address the need for research on Africana women. A conscious decision was made to emphasize research and teaching which focused on women in the Caribbean, Africa and the southern United States.

Administratively, the Center's activities are divided into three interrelated components: 1) the Africana Women's Studies Program (AWS) which offers Master of Arts and Doctor of Arts degrees in Africana Women's Studies; 2) the Africana Women's Research Collective (AWRC) which promotes and coordinates research for the Center; and 3) the Women's Institute of the Southeast (WISE), established in 1981, which is the networking/community outreach arm of the Center and which served as the base and catalyst for the development of the Center as a whole.

In addition to the Africana Women's Center, there are two other women's research and resource centers that focus on Black women. These centers have worked individually and collaboratively in sponsoring forums which address issues crucial to the Black female experience, and developing a network of scholars in Black women's studies. Spelman's Women's Research and Resource Center was established in 1981. Since its inception, the Women's Center has had three major goals: curriculum development, research, and community outreach especially to Black women locally and regionally. Spelman offers an interdisciplinary Women's Studies Minor, a unique women's studies offering not only because it focuses on minority women, but also because it analyzes women's experiences from a cross-cultural perspective.

The Spelman Women's Center has been engaged in several curriculum development projects which have included selected southern colleges. The Center is also involved in a collaborative project with the Center for Research on Women at Memphis State University and the Duke University/ University of North Carolina Women's Research Center. They jointly sponsor a working paper series, "Southern Women: The Intersection of Race, Class and Gender," designed to make new scholarship in history, social sciences and literature available.

The Center for Research on Women at Memphis State University has developed a Research Clearinghouse to address the problems of locating and disseminating research on women of color and southern women. The Clearinghouse is a computer-based information retrieval service available to teachers, students and scholars. (See Resources Section below for information.) The Memphis Center also offers degree programs and annual curricular and research development institutes.

Wellesley College's Center for Research on Women is an example of a non-Black institution that has developed special projects on Black women. The Minority Women's Research Program, established in 1981, concentrates on the experiences of Black women. They have a working paper series, an educational policy and research network, leadership and professional development programs, and were among the first to conduct a Black women's studies faculty and curriculum development project with Black colleges.

Black women's professional and community organizations have also become actively involved in developing resources, conducting research, and bridging the gaps between activists and academicians, between the "real world" and academia. A review of the focus of these organizations is in order. The Association of Black Women Historians, founded in 1978, was responsibile for the Black Women's History Project Bibliography which identified published as well as unpublished historical works on Black women. They continue to publish a newsletter on research in progress and new programs and projects. The National Archives of Black Women's History of the National Council of Negro Women has a collecting and identification project on Black women's organizations. The Southern Rural Women's Network in Jackson, Mississippi, is an obvious source to tap in doing research on Southern women and rural women. The National Black Women's Health Project in Atlanta has for several years been documenting through print and media the health situations of Black women. The Children's Defense Fund in

Washington, D.C., has a wealth of data and resources on child welfare, teenage pregnancy, and public policy.

The birth of Black women's studies was in 1970 with Toni Cade's anthology on Black women, but it came of age in 1982 when the work ALL THE WOMEN ARE WHITE, ALL THE BLACKS ARE MEN, BUT SOME OF US ARE BRAVE: BLACK WOMEN'S STUDIES was published. This work, edited by Gloria Hull, Patricia Bell Scott and Barbara Smith, is the only text in Black women's studies. It provides a wealth of data in support of various disciplines. Its extensive bibliographies and sample course syllabi offer data on the sources to be used in course development. This was the book that needed to be written, and it was written by three Black women who continue to be vigilant and persistent in their support of Black feminism.

The dearth of material by and about Black women and the absence of courses on Black women in Black studies and women's studies led to these beginings. Now that we have added the courses, trained the faculty, sponsored the conferences and forums, written articles, dissertations and books, and grappled with developing a feminist theory, the argument for Black women's studies ends as the argument for integrating the curriculum begins.

The two-year Development Project in Africana Women's Studies at Atlanta University was begun in 1983 as a model for training faculty at five Black institutions. This model was developed on the premise that Africana women, i.e. Black, Caribbean and African women, rural women and southern women, are generally neglected or omitted in the study of every discipline. The training of faculty at faculty development institutes, and the development and revision of courses have been the two strategies used to effect change in the curriculum.

Eleven faculty of the graduate schools of Atlanta University were selected as a core women's studies faculty who could (after a year of workshops, lectures, discussions, readings, and pilot courses) serve as resources for the undergraduate team. A month-long institute held in the summer of 1983 served as basic training in scholarship on Africana women. Consultants on curriculum development issues, scholars and community workers presented lectures, distributed bibliographies, discussed new research and materials, and served as resource persons.

Because Atlanta has over ten academic institutions and numerous community organizations all with a wealth of materials and archival resources, tours, site visits and lectures were scheduled to acquaint faculty with available local resources and to facilitate accessing collections and documentation. Representatives from community organizations such as the South Africans Against Apartheid group and Dua Afe, a group of Black lay midwives, led discussions related to their concerns and experiences. This institute was the vital ingredient in the first year of work. The first year continued with seminars on child abuse, domestic violence, Black male/female relationships and book reviews. These open forums for faculty, students, community workers and governmental officials provided the setting for an on-going interactive and broadening process.

During the first semester, faculty developed courses which were piloted in a variety of formats during the second semester. Our success story in piloting nine courses and in enrolling students in graduate courses in six disciplines is based on receiving approval for adding six courses to the curricula. Presently the faculty is composed of 5 men and 5 women. All are senior faculty members who serve on strategic committees and are respected in their disciplines. All courses taught by the five men have received curricular approval.

The second year of the project has been devoted to the development of faculty at undergraduate institutions: Hampton, Southern, Jackson State, and Atlanta Junior Colleges. In the Fall, after a three-day workshop and distribution of sample syllabi developed by the graduate faculty, fifteen faculty from undergraduate institutions returned to their individual institutions to develop courses in their respective disciplines to be piloted during the spring semester. Because of the constraints of time and departmental procedure, established courses were typically revised to include units on Africana women.

We found students excited about the new topics. We also found they were more politically conservative and less knowledgeable about women's studies, feminism, liberation or even famous Black women than we had anticipated. The faculty differed in abilities and beliefs in bringing about change and differed in levels of awareness of women's studies. What we found during our site visits were efforts to maintain and expand new curricula, to cooperate and support research activities, and a need for more intense faculty training. Curriculum approval remains uncertain at the undergraduate institutions where resources in women's studies are limited and faculty responsibilities are both greater and more varied. By and large, feminism and/or feminist perspectives are absent from the readings, approaches and constructs in the curriculum.

In Bell Hooks latest work, FEMINIST THEORY FROM MARGIN TO CENTER (1984), she states, "most feminist theory emerges from privileged women who live at the center, whose perspectives on reality rarely include knowledge and awareness of the lives of women and men who live in the margin." Many Black faculty and students see themselves as part of "the margin." Yet changes are occuring in the South and in Black colleges where curricular modifications have begun to address regional, gender and racial biases as well as including feminist perspectives.

The approaches used in Black colleges in incorporating women's studies, in developing a more gender balanced curriculum, and in integrating a feminist perspective, are not new. They are rather late in starting, but will undoubtedly continue. Our work has been slow because we have been burdened with ranking oppressions: is racism or sexism the major oppression? And we have failed to consider classism.

Because we were socialized to accept someone else's definition of Black womanhood, our approaches to developing and integrating curricular changes have been problematic and non-traditional. One approach to integrating the Black feminist perspective that is often used to create a receptive audience among students and sometimes faculty is to dispel myths about Black women. These include:

1) The Black woman is already liberated.
2) Racism is the only or primary oppression of Black women.
3) Feminism is anti-male.
4) Women's issues are narrow, apolitical concerns.
5) Feminists are lesbians.

Dispelling these myths allows us to look at the historical and contemporary realities and the false assumptions upon which stereotypes and myths are based.

Another problem has been understanding feminism and the feminist perspective. Our approach has been to examine the theories and conceptual frameworks to determine if they are applicable to the situations of multiple oppression of Black females. From the first Black feminist statement by Barbara Smith (1977), to the Combahee River Collective's (1977) political statement of their organization, to Bell Hooks first polemical argument on the inclusion of Black female experience in women's studies in AIN'T I A WOMAN (1981), to Bell Hooks' (1984) book on feminist theory, Black women's studies has struggled to develop a feminist conceptual framework in which to consider Black women's historical existence and contemporary conditions.

That framework can be best understood by the concept simultaneity of oppressions. That is, we see as our task "the development of integrated analysis and practice based upon the fact that the major systems of oppression are inter-locking" (Hull and Smith, 1982). A feminist perspective allows us to ask certain questions about data and sensitizes us to the way questions are raised.

What is offered to us in academia by these courses, projects, publications and research by, about and for Black women are ways in which the triple oppressions of gender, race and class can be understood in their specificity, as they shape the lives of Black women individually and collectively. I believe the resources developed, the records uncovered and used, the conferences and seminars sponsored, and the ideas and theories generated have made a significant and lasting difference.

References:

Combahee River Collective. 1977. A Black Feminist Statement. In Hull, Scott, and Smith, 1982.

Hooks, Bell. 1981. Ain't I a Woman? Black Women and Feminism. Boston: South End Press.

Hooks, Bell. 1984. Feminist Theory: From Margin to Center. Boston: South End Press.

Hull, Gloria, Patricia Bell Scott and Barbara Smith (Eds.) 1982. All the Women are White, All the Blacks are Men, But Some of Us Are Brave: Black Women's Studies. Old Westbury, NY: The Feminist Press.

Hull, Goria and Barbara Smith. 1982. Introduction: The Politics of Black Women's Studies. In Hull, Scott and Smith, 1982.

Lerner, Gerda (Ed.) 1972. Black Women in White America: A Documentary History. New York: Random House.

Loewenberg, Bert and Ruth Bogin (Eds.) 1976. Black Women in Nineteenth Century American Life: Their Work, Their Thoughts, Their Feelings. University Park: Pennsylvania State University Press.

Smith, Barbara. 1977. Toward a Black Feminist Criticism. In Hull, Scott and Smith, 1982.

Stirling, Dorothy. 1984. We Are Your Sisters: Black Women in the Nineteenth Century. New York: Norton.

Who's Who and Where in Women's Studies. 1974. Old Westbury, NY: The Feminist Press.

NURSING PRACTICE IN WOMEN'S HEALTH: A CONCEPT PAPER

Denise Webster, Linda Leslie, Beverly McElmurry, Alice Dan,
Diana Biordi, Diane Boyer, Susan Swider, Marcia Lipetz
and Joan Newcomb

This article, reprinted with permission, originally appeared in NURSING RESEARCH 35(3) MAY/JUNE, 1986:143.

The literature in women's health and accumulating experience in the provision of women's health care have resulted in the identification of some essential criteria for defining women's health practice. These can be organized according to the assumptions, content issues, process issues, structural issues and outcome issues involved in the provision of health care for women. They are consistent with various constructs within nursing theory.

Assumptions:

1. The human body, mind and spirit form an integrated whole.
2. People have capacity for self-care and self-healing.
3. Events and interactions in the family, community and world affect and shape the health of people.
4. Health care is the shared responsibility of society, the health care system and the individual.
5. Health reflects integrity, flexibility, the capacity to develop, and the capability to creatively transcend difficult situations.
6. Control over one's body is a basic right.
7. A woman's lived experiences are the starting point for future actions.
8. Woman's health care practice can occur in a variety of settings, including ambulatory care clinics, communities, hospitals and university settings.
9. By focusing on women, health care for all will be improved; men are not excluded as either providers or recipients.

Structural Issues:

Historically, nursing practice in women's health care has been primarily linked to reproductive health. The emerging practice in women's health care provides comprehensive attention to women from birth through old age, with an emphasis on illness prevention and health promotion. Thus, contributions are needed from a variety of perspectives working collaboratively.

In the health care of women, the provider and the client enter into an egalitarian and collaborative relationship. Each brings different strengths to this relationship. In particular, the provider brings scientific knowledge, and the client brings knowledge of her own body/mind/spirit and experiences. Women make health-related decisions and identify health goals in collaboration with the provider.

Process Issues:

Self-care is defined as the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health and well-being (Orem, 1985). There is a wide spectrum of self-care management capabilities. Together, it is the responsibility of the provider and the client to assess these capabilities, and plan care accordingly.

Content Issues:

Women's health encompasses care throughout the life-cycle, and recognizes a body/mind/spirit synergy. The assessment of a woman's health includes the collection of information about physiological state, life-style issues, interpersonal relationships, occupational status, and social/institutional activities, while also recognizing the individual's right to privacy.

Health promotion and illness prevention are emphasized during encounters in a women's health practice. The provider shares information that enables the client to modify self-care practices and minimize risks.

Outcome Issues:

Women's health practice is process-oriented. Health care is a continuing process as well as an outcome. The woman has the ultimate responsibility for and control over self-care. The provider encourages people to trust themselves as sources of knowledge, and to learn about alternative sources of knowledge as well. Thus, outcomes include increased knowledge, increased self-confidence, absence of illness, expanded competence in self-care, and an increased sense of choice and control. The overall goal of health care is to enable women to make choices that expand their ability to care for their health and effectively use sources of illness care when necessary.

Reference:

Orem, D.E. (1985) Nursing: Concepts of Practice. Third edition. New York: McGraw-Hill.

III. INTEGRATING MINORITY WOMEN'S HEALTH INTO CURRICULA

SECTION INTRODUCTION

This section had its origins in our experiences at the Summer Institutes. Despite availability of our bibliography on minority women's health, many faculty/participants expressed hesitancy about integrating such materials into their lectures and courses. They were often unsure how to begin and uncertain about their own skills and knowledge in these areas which have been underdeveloped in women's health studies curricula. We therefore organized specific sessions at the latter two Institutes not only on substantive issues in minority women's health but also on curriculum integration strategies. Most of the articles in this section were originally presented in the curricular integration sessions. Participants in the Summer Institutes found these materials extremely useful and felt enabled to integrate new materials and teach new substantive areas.

Sheryl Ruzek's overview focuses on both practical and theoretical aspects of integrating minority women's health issues into the curriculum--from acquiring needed resources to implications for reconceptualizing health and illness. Ruth Zambrana's paper on "Fundamental Issues in Teaching About Minorities," originally presented elsewhere, provides a basic framework for faculty initially attempting to teach about minorities. A core point is that regardless of minority status, everyone must learn new materials to teach in new areas.

Diane Lewis' paper offers a short history of the integration of minority health in liberal arts institutions through a focus on Black and women's studies. She also includes strategies for the future and provides some sorely needed perspective on our achievements to date. Ruth Zambrana's second paper focuses on the integration of minority women's health issues in the curricula of health professional schools. The challenges that addressing these topics pose for conceptualizing health and for considering the organization of health care delivery are discussed. Karen Ito's paper provides a case study of curricular integration focused on Asian/Pacific American women's health. She gives us a strong sense of the need to frame minority women's health in terms of the history of the group in the United States as well as in terms of socio-cultural issues.

INTEGRATING MINORITY WOMEN'S HEALTH INTO THE CURRICULUM

Sheryl Ruzek

Throughout the Women, Health and Healing Project, we have attempted to focus attention on topics which are under-represented in college, university and professional school curricula. We are particularly concerned with directing attention towards the health of minority women for many reasons. First, it is imperative that we do so in order to train students to be aware of and sensitive to the needs of minorities in their professional work. Second, we must do so in order to make the health sciences reflect more accurately the very nature of health and illness.

In this paper I briefly discuss why we regard stimulating both research and teaching on minority women's health as so critical. I shall also describe how we are attempting to do this--with the Minority Women, Health and Healing in the U.S.: Selected Bibliography and Resources (Ruzek, Clarke, Anderson, Hill 1986), with these papers written by our Summer Institute guest faculty--Karen Ito, Diane Lewis, and Ruth Zambrana, with our continuing collaboration with the Memphis State University Database on Women of Color and Southern Women. I shall also make some suggestions as to how others might use the resources described here.

WHO NEEDS TO LEARN ABOUT MINORITY WOMEN'S HEALTH?

We assume that the importance of teaching minority women's health to sensitize future practitioners, policy-makers and scholars needs little explanation. At each of the Summer Institutes, faculty reported that learning how to do this was a high priority. Few participants had learned anything about minority women's health in their own professional education, and a substantial number now face teaching students who are members of minorities and/or who will provide health care to minority women. For those actually facing the uncertainty of how to do this sensitively and effectively, motivation is high. Any help they can get in locating material and developing a multi-cultural perspective is welcomed.

But not all faculty are in such a position, or even if they are they manage to ignore gnawing questions about the relevance of what they are teaching to their particular students. Others throw their hands up in despair over the lack of materials and the lack of time in the curriculum to "cover everything." Still others regard it as an imposition to be asked to cover what they see as overly narrow or specialized subjects. In these situations, students who wish to pursue special projects are too often dissuaded from doing so on grounds that "there isn't any literature" or that the topic "isn't important." We need to examine some of the assumptions that underlie these perspectives.

"HOW CAN THIS BE INTERESTING UNLESS YOU'RE ONE OF 'THEM'?"

When Susan Reverby, the Wellesley College historian who is writing a book on nursing, spoke at the 1986 Summer Institute about her experience of doing her research and presenting it, she commented that when people discovered that she was not a nurse, they looked at her and asked, "Well why are you doing this if you're not a nurse?" The response reflected the institutionalized view that nursing, the prototypically female profession, could not possibly be interesting or important to study in it's own right or for what it might contribute to social history, the history of the professions, or the history of health care.

I have had a similar experience working on the resource material on minority women's health. Whereas Susan Reverby can credibly be assumed to be a nurse until she reveals that she is not, I am never presumed to be a member of a racial minority. So I am often asked quite directly and often with puzzlement why I am doing this work, why I am interested in the health of minority women. I believe that this reponse reflects the depth of the view that anything other than the majority dominant perspective is peculiar, something that requires explanation, unless of course the person interested is "one of them." I find this disturbing for many reasons, one of which is that we need to study the health of minority women to increase our understanding of health and illness in some very fundamental ways. When we consider the experience of minority women we may develop a very different view of what constitutes health and illness, health seeking behavior, and the history of health care than if we exlclude minority women from our consciousness and our scholarly work.

HOW THE METHODOLOGY OF SCIENCE EXCLUDES MINORITY WOMEN

We do not understand health and illness very well. Epidemiological research certainly does not reflect what it ought to reflect in terms of our understanding of general disease processes, particularly social aspects of disease, because we exclude from research persons other than members of the dominant group. This gives us a very distorted view of disease processes. The one I am most familiar with at the moment is heart disease. For those of you who are not familiar with it, it is treated as a "man's disease" socially, culturally, and in clinical situations. Lois Monteiro (1982) has observed the extent to which this cultural myth obscures certain key features of the disease and impedes both research and treatment. Although low income black men have high rates of heart disease, it is white men on which most research has been done. Thus our understanding of the disease process rests on epidemiological studies and intervention trials done on subjects who are almost exclusively white, middle and upper class men. Our whole perspective of the world is based on an assumption of whiteness and frequently maleness.

We know almost nothing about heart disease in women because it has not been studied. I've struggled with this alot. When I first began to do my own research on it I was told "But that's a man's disease." When I argued that while men's rates are higher, heart disease is still the leading cause of death in women over the age of 50. Then I was told that research on women would cost too much because I would need more subjects to follow and I would have to wait too long to get enough deaths to analyze.

I am increasingly convinced that in addition to the value biases of those in control of research funds, the actual methodology of science makes if difficult to learn what we need to learn. I want to mention just a few things. Those of you who have studied statistics know how you have to structure research so that you get rid of "noise" so that you can identify your causal factors. Well, I don't have to tell you what a minority woman does in a researcher's sample--she creates "noise." So we have to get rid of these people who might introduce intervening variables and/or present trends which might dilute or mask the "dominant pattern." So we define our sample subjects more narrowly and more narrowly, thinking that we will get down to identifying what ever it is we want to identify. We justify this on grounds that by reducing variation we can achieve statistical significance more readily--and it is indeed true. In research terms we have opted for homogeniety and in doing so must sacrifice external validity--the generalizability of our findings. If we in fact later repeated studies on different populations, populations composed of minority women, for example, we could of course eventually come to understand what factors are involved in health and disease processes in the human population. But this is not what we do.

What we do instead is quietly ignore the dictum that every student learns in basic research methods--that you can not generalize beyond the population from which a probability sample has been drawn. In health research and practice this is violated wantonly and without attention to the institutionalized race, gender and class bias that is literally built into most research methodology. We ignore who has been excluded from samples and leap forward to declare that research findings are widely generalizable. What we "know" scientifically that applies to our circumscribed population is taken to apply to "everyone." We have linguistic conventions that help us do this. We have an example of how this comes about very close to home.

THE LANGUAGE OF INCLUSION AND EXCLUSION

The Summer Institutes were held on the Berkeley campus of the University of California, where some sessions and meals were held at the two "Faculty" clubs. There is always confusion about the "Faculty Club" as contrasted to the "Women's Faculty Club." At Berkeley, there are separate faculty clubs for women and men, although both facilities are used by both men and women. In such circumstances, if you say faculty, the expectation, the norm, is male. If you have a faculty club for men, it doesn't "need" to say "men's"; it is just assumed. Now if there is a separate facility for women the word "women" will indeed be added. As many scholars have pointed out, we always add a special term when the person we refer to violates the norm and must be set apart. We all recognize this in daily language. If we have invited a lawyer to lecture to our class, what do we say? We have invited a woman lawyer. What do we expect? What kind of woman? A white woman. And if we've invited a black woman lawyer, what do we expect? A heterosexual black woman lawyer. The levels of assumption go on and on. This is more than just convention; there are, in fact, conceptual hierarchies which reflect prevailing norms. They are ways in which we order our expectations about the world.

The National Council for Research on Women is putting together a thesaurus of key words to use with databases on women because we don't "fit" the dominant conceptual orders. The scholars working on the thesaurus project are trying to come up with key words that will allow us to do research on women's issues in our own conceptual framework. As it turns out, this is very hard to do. They are trying to come up with some uniformity of classification. But when you start looking at the way scientific literature and scholarly works are classified for key words, there are many hierarchies in classification that are obscured. There are more inclusive categories and there are more exclusive categories. These hierarchies of generality and specificity affect our thinking as well as our ability to "retreive" scientific findings efficiently and effectively.

DEALING WITH DIVERSITY

These linguistic assumptions are very important for us to think about in terms of how we organize our own teaching materials, how we organize the curriculum. It is a central issue in how we integrate minority women's health into the curriculum and how we key-word classify the scholarly literature which directly involves minority women. They raise questions about how we teach. How do you deal with general issues? How do you deal with the diversity within racial and ethnic groups? Our guest faculty rightly ask how they can, for example, talk about the health of Asian-American women when there are so many distinct groups. We recognize the extent of the problem. What we are trying to do here is set into motion a process that has many stages. We have to generate awareness, we need to stimulate research, we have to figure out how to disseminate research, get it used and legitimize it. These are enormous tasks fraught with all kinds of difficulties and tradeoffs. What our Summer Institute guest faculty were asked to do was to share some of their ideas about how minority women's health might be better integrated into the curriculum. Karen Ito, Diane Lewis, and Ruth Zambrana who presented at the Institutes have all had to deal with the conflicts and contradictions inherent in this endeavor. In their papers in this volume they address both structural features of academic institutions and content and process aspects of teaching about minority women. Their papers reflect many years of experience as minority women scholars attempting to address minority women's issues in predominately white academic institutions.

MOVING BEYOND "THERE ISN'T ANY LITERATURE"

All of our guest faculty address the fact that there is a widespread view that there "isn't any scholarly literature on minority women's health", so one can not teach it. This is one of those multiple realities with which we have to grapple. On the one hand, it's true, the body of knowledge is limited. At the same time, it is incorrect to declare it as nonexistent. I am very disturbed when students come and say, "I wanted to do a term paper on something about Black women, Chinese women, or whatever, but Professor So and So said that there wasn't anything in the literature on this so I couldn't do it." Is that really true?" Sometimes Professor So and So is right, but often the statement "there isn't any literature" means, more accurately, that the professor is just not aware of it. We selectively perceive those articles which we already hold to be important and screen out of consciousness those we deem "unimportant." In addition, the growing literature on minority women's health is scattered in a wide array of disciplinary journals and is sometimes printed in conference proceedings or other "marginal" publications which are not well indexed. The bibliography we compiled is designed to give faculty a tool for directing students to the work that does exist. We hope the bibliography will help faculty to say to students who inquire about the literature, "Actually, there is quite a growing literature. Look at all these references on minority women."

I like to carry the Bibliography around with me and at every opportunity say, "Gee, you should see the explosion, the absolute explosion of research and scholarship on minority women's health taking place in this country." So in certain arenas I emphasize how much there is and in others I emphasize how much more we need. Here we can talk honestly about how little there is in relation to what is needed. Both are "true". There is an impressive amount available if you know where to find it. So we are involved in two complimentary processes. We urge scholars to create new knowledge and to use the knowledge that currently exists.

HOW TO USE THE BIBLIOGRAPHY

In women's studies, as Diane Lewis points out, we did not have the luxury of being trained as women's scholars. We had to learn it on our own. She in fact has had 26 years of experience in creating both ethnic studies and women's studies from ground zero. All of our Women, Health and Healing core faculty were faced with this. We had to teach ourselves because when we started doing this over ten years ago, there really was no recognizable body of literature on minority women's health. All along we knew that we should be doing more, but we didn't havematerial nor did we individually have time to locate much. It was really very frustrating. When you want to do something, when you know you ought to do it, but do not have much time we know how you end up using anything you can find. Sometimes it's not very good, and we all struggle with this.

One of the most effective ways a faculty member can learn new areas is to have their students teach them. I want to underscore this. You will have students who will teach you an enormous amount if you encourage them to do so. As the population of college age students shifts from being predominantly white, middle-class and privileged to including more racial and ethnic minority students (as some of us are already seeing) this will become a reality. You're going to have students come in and say, "I want to do something on Black women, Puerto Rican women, Native American women. These will be topics you very likely know nothing about. Now we have to be comfortable with the fact that there are many areas--even in our "specialty areas"--in which we don't know alot. What our role then becomes is guiding students in methods, structuring research projects, and heading them in the direction of literature which will be appropriate. This bibliography is intended as a tool to facilitate this. I want my colleagues to be able to say to the student who wants to do a paper on some aspect of minority women's health that although he or she does not know the literature, here is a bibliography. If the student then writes a paper, that faculty member will see this paper and will learn something. And with graduate students, of course, the students will not just be working at this basic level. They may be in the process of producing material which can be published and disseminated much more widely. So we hope to set in motion the process which will serve as a catalyst for the creation of additional scholarship.

To make this bibliography accessible to students, it's good to carry it around in your bag, have extra copies in your office, put it on reserve for your classes in your library. Put it in the reserve book room and in the main library yourself or specifically ask that it be ordered. Don't wait for the library to "discover" it or put it there for you. I also like to indicate on the course syllabus that it exists and suggest that if students want to choose a term paper topic they might browse through the bibliography to get an idea of what exists.

I want to note that we had a dilemma in terms of how to organize this bibliography. In early drafts we did not have to deal with how to classify or classify because there was so little that there was nothing to subclassify. As we worked on it we became alarmed by the quantity of material. How would we divide this by topics, by racial or ethnic groups, by historical or contemporary work? I spent several days at Memphis State University meeting with the bibliographers, archivists, database specialists, and others involved in their Database Project. They urged us not to try to classify too much too soon. To meet the needs of people who do want more classification, the Database Project will enter all of the references in Minority Women, Health and Healing in the U.S. into their computerized data bank. They will assign key words to material so that scholars will be able to retrieve citations efficiently. We are relieved of the terrible responsibility of classifying beyond the broad categories we used. With the Memphis State University Database System, you will not have to dig through 500 references on Asian American women to find the fifteen on Hawaiian women. With their computer search procedures they will cut it down. If you limit your search in several ways, you might only get two references, but the two references will probably be useful. Information on how to request computer searches is included in section V of this volume.

At the urging of our colleagues at Memphis, we also created a one page bibliography on minority women's health--just a few "key references." We were hesitant to make such a selection, but knew that it was essential. We all get constant requests from colleagues who really want to add material to their classes--sometimes just a single lecture or reading. If we hand the whole bibliography to these colleagues, we know the next question is going to be, "Well, what should I read out of all these because I don't know anything?" We have to be prepared to give something to people who are really ignorant and don't have the time to do alot of reading. When we create the awareness of the importance of including material on minority women's health we have to provide mechanisms to allow that to happen. The short list of references is included in the bibliography and reprinted in this volume. We hope that you will copy it for your colleagues.

GETTING RESOURCES INTO YOUR LIBRARY

References are useful, but students need to be able to find material in the library. To increase the availability of material, I would like to suggest that you use the bibliography as a means to get to know a librarian. On every campus I have ever known, there has been at least one acquisition librarian somewhere who was sympathetic to women's issues and at some level concerned with increasing the collection on minority women. Health is easy to sell. Make an effort to find that librarian and take her or him to lunch and talk about how to expand your library's collection of these materials. You might also offer to serve on your institution's library committee.

If you don't want to take a librarian to lunch, or you don't have time, or it makes you nervous, or you think they're not friendly, or you've gotten nowhere after you've taken one or more to lunch, what are your chances for getting more material into the collection for student use? Every library that I've known about has felt obligated to purchase (usually quickly) all required readings requested to be placed in the Reserve Book Room. In my experience, when I request books for use in my classes as "Required Readings" the library will buy these books. It always works! If you need quite a few items, it is a good idea to make an appointment with the Reserve Book Room staff. Also, if you submit reserve book lists early, the staff will start to like you for your promptness. If you're only asking for a few new books each term or discuss your need for material for a new course well in advance, you can often get what you need.

NEEDS FOR FURTHER WORK

We feel that there is still much work to be done to integrate minority women's health into the curriculum.

The resource material which we have generated is just a preliminary step. We particularly see the need for annotation of key references, for developing workshops to train faculty to use existing material, and for the preparation of lecture material, audiovisual aids, and classroom exercises which can be used easily by faculty who do not have the resources to develop their own material. In the future, we would hope that technical assistance might be made available to institutions interested in increasing their collections and providing faculty with assistance in revising their courses. Such activities might best be carried out on regional basis.

Ultimately, the material we have available to use in teaching comes to us as the result of scholarly research. Thus no discussion of post-secondary education can ignore the topic of research and scholarly production. Increased recruitment of minority faculty is key to recruiting and retaining minority graduate students who in turn will increase the availability pool of such scholars. While we would hope that most minority women's health issues would not be the research task of minority scholars alone, in reality such scholars are more likely to carry out such work and with greater sensitivity to issues of race than most majority group scholars. Increasing the legitimacy and visibility of research on minority women's health issues will encourage young scholars to undertake this work. We all have much work to do to make this a reality and to see to it that this new scholarship is fully integrated into curricula in post-secondary education.

References

Monteiro, Lois A. (1982). "Who Has Heart Attacks? Gender Related Perceptions of Myocardial Infarction". Paper presented at the Medical Sociology Section session, American Sociological Association Meetings, San Francisco.

Ruzek, Sheryl, Adele Clarke, Pat Anderson, Virginia Olesen and Kristin Hill (1986). Minority Women, Health and Healing in the U.S.: Selected Bibliography and Resources. San Francisco: Women, Health and Healing Project, University of California.

FUNDAMENTAL ISSUES IN TEACHING ABOUT MINORITIES

Ruth E. Zambrana

Anyone who has attempted to integrate materials on ethnic minorities into the curriculum knows that this is a difficult and never-ending task. In this article I discuss some of the difficulties faced (1) from a theoretical perspective; (2) from the student's point of view; and (3) from the instructor's point of view. I conclude with some recommendations of strategies for integrating different materials into the curriculum.

Theoretical Issues:

What is the current state of the art with regard to teaching about minorities? Most textbooks do not include a realistic overview of the heterogeneity of the population in the U.S. Moreover, more often that not they lump all ethnic diversity into one group, the "nonwhites," and/or generalize about groups and thereby reinforce stereotypes, such as "most Latinos have language difficulties" or "all Blacks are poor and uneducated" (in fact 40% are middle-class). Second, there is no accessible theory as yet to explain to undergraduates in simple terms the patterns of class and racial stratification in the U.S. Most such work involves either highly complicated Marxist and economic approaches or esoteric sociological jargon.

Third, the sociological and anthropological literature has tended to view the study of ethnic minorities as outside of the mainstream, as "exotic" (witness the study of folk medicine), or has viewed minorities as being part of the mainstream when they "melt into the pot," which has not occurred. This lack of attention in the textbooks to both inter and intra group diversity represents a discriminatory ideology, regardless of intention. The lack of willingness to accept and discuss racial and cultural differences consequently devalues minorities in the U.S., including people of color, lesbians and gays, and the disabled. The lack of texts which provide good overviews of racial/ethnic minorities as part of U.S. society leaves instructors with little choice but to provide additional materials and/or attempt to "force" what is written to apply to minorities.

Students' Issues:

When students enter college they already possess certain attitudes towards those who are different and those with whom they are not familiar. Much of the college population, like much of the larger U.S. population, has had little exposure to the diversity of individuals in this society. This true not only for Anglos, but also for Blacks and Latinos who often are not familiar with Anglo culture. Essentially there is a lack of experience with those who do not share our religious, class, racial and cultural background. Elementary and secondary schools tend to inspire a naive and stereotypic nationalism, such as that "Russians are evil," "Mexicans are short and dark," and

"Africans are tribespeople." Most schools tend to use history textbooks which present narrow and biased viewpoints.

All of these factors contribute to our students' resistance to new ideas. Even at the university level I have encountered extreme stereotypes, such as that Blacks are foreigners and that Latino families, because of "machismo," do not allow their female children to obtain an education. In most instances, the students expressing these views were intelligent and sensitive. They simply had never been exposed to other realities.

New ideas and knowledge often challenge the roots of students' beliefs and their personal world views, which can be quite emotionally disruptive. I once had a young, white male student from a strong religious background. In the class we talked a great deal about gender and the special needs of women, including choices such as abortion, as well as the different needs and values of Black and Latina women. After a couple of weeks the student began to fall asleep in class. When I spoke with him he said he was tired and was not going to keep himself awake by drinking coffee like me and "those other women" (referring to the "feminists" in the class). When another faculty member spoke with him, the student said he didn't like me, that I talked about odd things. He later told me he felt I was trying to change all his values and his person. The lesson here is that such material, in strong doses, can fundamentally shake the persona of the individual. Sensitivity is critical to avoid overwhelming students and, conversely, to avoid "overprotecting" them from experiencing the emotions that come with exposure to new peoples and new ideas.

Instructors' Issues:

As instructors we operate under several important constraints when we set out to integrate racial/ethnic content into the curriculum. First, it takes a lot of energy and time, and many faculty members already have overcommitted schedules. It is not easy to find materials which fit the needs and levels of the students and the requisites and level of the course. Moreover, such available resources as the Journal of Racial and Ethnic Studies, the Black Scholar, and even the Psychology of Women Quarterly (special issue on Black Women) are absent from many libraries.

Second, faculty as well as students are not always up to date on recent issues or even on the basic history of minority groups in the U.S. Here I can give my own case as an example. Growing up on the East Coast, I had a very narrow view of where the U.S. began and ended, who Asians were, and the history of Black Americans. I was fortunate when in 1980 three sociologists invited me to collaborate on a project on the comparative historical experiences of women of color in the U.S. - Black, Asian (Chinese and Japanese) and Latina (Puerto Rican and Mexican-American). I have learned a tremendous amount while working on this project for the last six years and have become more aware of my own biases, ignorance and stereotypes. For example, as a Puerto Rican, the history of Mexican-Americans came as an eye-opener.

I had not known that 5 of the Southwestern states were once Northern Mexico. I was also unaware that the majority of the few Chinese women in the U.S. in the nineteenth century were prostitutes. I am still learning about Asian cultures. Although I am now knowledgeable about their history in the U.S., I have little practical experience with this population. The point is that we are part of a system which has not provided us with an accurate history of racial/ethnic minorities in the U.S., and it takes a tremendous amount of work to obtain the complete context for understanding the diversity among the groups. Instructors need to first become culturally competent, a difficult task in itself.

Recommended Curriculum Integration Strategies:

Once instructors have identified relevant teaching materials and have attained a degree of cross-cultural knowledge and competence, the issue which remains is how to weave these materials into the curriculum in ways which make sense. Over the last few years I have used a number of strategies which have been well received and have helped students to better understand and integrate such new materials.

I have developed a structural framework which addresses the issues of diversity with particular reference to class, gender, race and culture. I begin with a simple chart outlining the political, economic and social structure of the U.S. in order to examine the values implicit in democracy and capitalism. I then present the social class composition of the U.S. (approximately 70% working class, 15% middle class, 9% professional and upper middle class and 6% upper class). Issues of gender are presented first because in some respects these are the least threatening. Then I move to issues of class using, for example, Lillian Rubin's Worlds of Pain (1976). Following this I introduce issues of race and differences by ethnic background. Often students will make comments which provide good opportunities for initiating discussion of class and cultural differences within the dominant culture, as happened when one young Anglo woman talked in my class about the "hypocritical, emotional, two-faced" family of an Italian family.

Presenting such a framework in the beginning of a course provides students with a conceptual tool with which they can organize some of the new knowledge, and I find it useful to refer back to it. This particular structural framework can serve as a prototype, and other instructors will certainly develop their own. The point is that prior to teaching material on racial/ethnic minorities we need to provide our students with a broader perspective of the diversity in the U.S. and challenge the myth of the melting pot and that everyone can pull themselves up by their bootstraps.

There is a need to introduce materials in media that are stimulating, such as films and novels. For example, Monica Sone's Nisei Daughter, Alice Walker's The Color Purple (a bit strong for some), and Maxine Hong Kingston's The Woman Warrior are titles that I find valuable. Also, some ethnographic and community studies are engaging reading, such as Carol Stacks All Our Kin and Ruth Horowitz' Honor and the American Dream.

At the same time, we must be cautious about the materials we assign. First, we should be careful not to prematurely assign radical materials which may, for naive readers, reinforce stereotypes. Such works include books by Angela Davis and Bell Hooks, and Moraga and Anzaldua's This Bridge Called My Back. Second, we must become aware of those books which present stereotypic depictions of racial/ethnic life, such as works by Lewis (1965), Madsen (1961), and Sheehan (1975).

All readings need to have a context or be contextualized explicitly in classwork. I usually require students to read about people different from themselves in terms of class or race, and then to indicate in reaction papers how their experiences and values differ from those in the readings and what new knowledge they have gained. It is of interest to note that if given a choice, majority culture students will not read on color issues but prefer personal manifestations of class such as those found in Rubin's work. Therefore we need to require students to read about people different from themselves. Before such assignments are scheduled, it is helpful to prepare students for the reading, sketch what they will read about, and begin to give them a vocabulary for thinking about and discussing issues related to race, class and gender.

I also encourage students to discuss their own biases in their papers and even in class. For classroom discussions, of course, the instructor must take careful responsibility in setting the tone and in managing any difficulties and bridging the "learning gaps" among students of different backgrounds and races. Dominant culture students need to be able to examine their values and culture and not feel the guilt of not having a "special" culture and also not feel burdened for the "sins of their ancestors." The other important caution is not to burden racial/ethnic students with the responsibility of representing their entire race in the classroom.

We as faculty must take the initiative for meaningful exchange. Students are commonly awkward and silent during initial discussions. It is likely they have never participated in such discussion in "public" before, and we must "break the silence." An often fruitful strategy is to describe your own learning processes about other social groups, including awkward incidents and fears of appearing racist or insensitive.

In didactic lectures, different examples of how theories and practices apply and vary in terms of dominant culture, Black, Latino and other groups are essential. It is very important to present both similarities and differences here. For example, in family discipline issues, I try to break the myths of racial/ethnic exotic behavior. There is an emphasis on class as a key variable which cuts across racial differences. Culture is discussed as a dynamic concept and phenomenon which serves to diminish notions of cultural determinism and enhance understanding of the ranges of variation. For example, in psychology or social welfare courses one can discuss the values of the society (ideology), how they are played out in distribution of funds for programs, and how this affects various communities, organizations and survival. Then one can point out how individuals and families within the communities are in turn affected by community resources, and the consequences for families who have little access to resources. Another approach here, also an effective method of applying psychological theory to different groups, is the assignment of a short story about a different racial/ethnic group and asking students to discuss why the theory does or does not apply based on issues of class, gender and race.

Clearly for each course we teach, and for each group of students, we have to find a different approach. At the undergraduate level we primarily want to open students' minds to other worlds. The point is to develop a framework which is comfortable for us as instructors. In conclusion, the goal is to develop a sense of cultural competence and awareness, which I believe at its most fundamental is simply accepting that others are different, and that difference is something to value rather than to suspect.

Notes:

1. This is a revision of a paper presented at the Western States Project on Women in the Curriculum meeting, Integrating Women's Studies into the Liberal Arts: A Conference for Project Leaders, April 4, 1986, Santa Monica, California.

2. There is a growing number of university of community resources which are potentially valuable to both instructors and faculty, such as the following:

   Memphis State University, Center for Research on Women, Bibliography on Women of Color. Memphis, Tennessee.

   Ethnic minority centers such as those at UCLA (including its Spanish Speaking Mental Health Research Center) and the Hispanic Research Center at Fordham University.

   Becoming acquainted with individuals in such institutions and areas is very helpful in keeping abreast of the newest available knowledge and resources.

References:

Davis, A. Women, Race and Class. New York: Random House.
1981

Hooks, B. Ain't I a Woman? Boston: South End Press.
1981

Horowitz, R. Honor and the American Dream: Culture and Identity in a
1983 Chicano Community. New Brunswick, New Jersey: Rutgers
University Press.

Kingston, M.H. The Woman Warrior. New York: Vintage Books.
1977

Lewis, D. La Vida: A Puerto Rican Family in the Culture of Poverty.
1965 New York, Random House.

Madsen, W. Society and Health in the Low Rio Grande Valley. Austin,
1961 Texas: Hogg Foundation for Mental Health.

Moraga, C. and G. Anzaldua. This Bridge Called My Back. Watertown,
1981 MA: Persephone Press.

Rubin, L. Worlds of Pain. New York: Basic Books.
1976

Sheehan, S. A Welfare Mother. New York: Signet.
1975

Sone, M. Nisei Daughter. Seattle, Washington: University of
1979 Washington Press.

Stack, C. All Our Kin. New York: Harper and Row.
1974

Walker, A. The Color Purple. New York: Harbrace Jovanovich.
1982

INTEGRATING MINORITY WOMEN'S HEALTH INTO LIBERAL ARTS CURRICULA

Diane Lewis

My focus here is on integrating minority women's health issues into the curriculum in liberal arts colleges and universities. Women's studies and ethnic studies programs offer the greatest potential for integrating minority women's health perspectives into the curriculum on liberal arts campuses. These programs began in the late 1960s and early 1970s, and together, at their peak, numbered over 800. In 1982 there were some 25,000 courses in Black and women's studies alone (Sitkoff, 1982:36). The two areas have generated high quality research on race and gender, new curricula, and innovative teaching methods.

But ethnic and women's studies had another goal besides the development of innovative scholarship and specialized academic programs. This was the transformation of the traditional mainstream curriculum. This goal, sadly, has not been met. Florence Howe, then editor of the Women's Studies Quarterly, wrote about women's studies programs in 1975:

> If by 1980, the number of courses and programs has doubled or trebled, and if in freshman English, the students are still reading male writers on male lives, and in United States history the students are still studying male cultural heroes, wars, and male political documents, then we shall have failed our mission (Sitkoff, 1982:39).

Currently, the reading list of humanities sequences at major universities such as Columbia still lack any works by or about women. Publishers have not made major revisions in the standard texts, which generally have less than two percent of their content on minorities and women. Most male academics continue to teach traditional white, male-centered content and to ignore the concerns of minority men and all women (Sitkoff, 1982:39). As long as ethnic women's concerns are omitted in the general curriculum, we have a major structural barrier to integrating minority women's health and other perspectives on liberal arts campuses.

Another barrier to incorporating minority women's issues lies in the current decline of ethnic and women's studies on liberal arts campuses. Both programs are now under attack by administrators and wider communities which did not want them in the first place. Due to budgetary cutbacks, many programs have been dismantled or threatened, and most are suffering from inadequate, unstable funding and staffing. Minority and women's faculties, still concentrated in the lowest academic ranks, have commonly been unable to protect their position.

The situation is exacerbated by decreasing student enrollments in ethnic and women's studies programs, as students have begun to turn to career-oriented classes. For example, in the early 1970s, several thousand students majored in Black studies. In 1982, there were less than 300 majors (Sitkoff, 1982:36-39). Black and other ethnic studies are currently "in a benign neglect situation" on most campuses. Similarly, feminist courses in an area such as women's history reach less than 10% of the student body nationally. Many programs have been internally torn by controversies over class, race, and sexual preference as both political and curricular issues. To make matters worse, major foundations such as Ford, Mellon, NEH, and the Carnegie Foundation, which formerly supported minority and women's course development, conferences and professional training, have now greatly reduced their budgets in these areas (Sitkoff, 1982:36-39).

A third barrier to the integration of minority women's health perspectives in a liberal arts curriculum lies in the ideology and structure of ethnic studies and women's studies programs themselves. Although these are the two programs on any liberal arts campus where one would expect to find minority women's issues aired, in fact, women of color have been for the most part ignored.

Ethnic studies programs tend to be male-dominated in terms of the directors, faculty, course content. At U.C. Berkeley, for example, only two out of eight Afro-American studies faculty are women. Ethnic men tend to see ethnic women's studies as women's work, not realizing the need to re-educate themselves (Off Our Backs, 1982:23). Just as it is imperative to include women and minorities in courses in the wider curriculum, it is crucial to offer ethnic studies courses which deal with both women and men. Only in this way can we present the complexities, and not just the generalities, of ethnic experience (Cole and Gordon, 1981).

Women's studies programs have also omitted minority women. On most campuses, women's studies focus upon, are taught by, and are taken primarily by middle-class, white women (Avakian, 1981). The absence of minority perspectives and minority materials in many women's studies courses can be partially explained by the fact that women's studies faculties have themselves been trained in traditional disciplines which have ignored third world people.

When women's studies teachers are challenged to make their courses multicultural, they often resist in the same way that male faculty do when asked to include women's perspectives in their courses. They plead ignorance, claiming they don't know what books to read and assert they are not qualified to teach subject matter dealing with the views of women of color (Bazin, 1983:4). It is true that integrating minority women into women's studies requires additional research and faculty preparation. Consider, however, that most women's studies faculty never took a course in women's studies. They had to learn the subjects on their own from scratch (Bazin, 1983:16-17). They can do the same for minority studies as well. Incorporating minority perspectives in women's studies programs can immeasurably enrich the curriculum. A more wholistic grasp of women's lives and a more authentic reality could be presented in the classroom (Bazin, 1983:17).

Now that we have reviewed the barriers, let us consider factors that facilitate integration of minority women's health perspectives into the curriculum. I will focus on positive trends in Black and women's studies. First, the growing body of research in ethnic and women's studies is now generating a rich, new scholarship on ethnic minority women. The 1980s have seen books and entire journal issues reporting research findings on all aspects of Black women's lives. Currently, research on minority women is being supported by established women's research centers, such as the Wellesley College Center for Research on Women. Its program on minority women has produced policy development research on Black and Chicano women (Wellesley College Center for Research on Women, 1985). Spelman, a Black women's college in Atlanta, recently formed a new Women's Studies Institute, which will doubtless encourage additional research on Black women.

In terms of health, the National Black Women's Health Project, whose major goal is the education of Black women in self-help on health issues, should also contribute importantly to research and teaching on Black women's health (Avery et al., 1984). The new Black women's journal, Sage, devoted its Fall, 1985 issue to Black Women's Health. This burgeoning of research on Black and other ethnic women should have a major impact on the integration of minority women's health and other perspectives in the curriculum.

A second positive factor stems from the current structural position of both women's and ethnic studies. Since both programs are now under fire, they are more motivated than ever before to cooperate in fighting common enemies. Minority women's studies advocates find themselves in a critical position to help bring these areas together. In 1983, a 5-college consortium in western Massachusetts met to plan strategies around coalition-building between Black and women's studies. This kind of cooperation is bound to encourage the introduction of Black women's issues on liberal arts campuses (Hull, 1983:5).

Third, within most women's studies and Black studies programs, there are signs that faculty are becoming responsive to the need to integrate Black women's perspectives in the curriculum. Many women's studies programs over the past few years have been concerned with racism. This is reflected on some campuses in attempts to hire women of color or to teach courses on minority women's issues (Avakian, 1981; Off Our Backs, 1982). The National Council for Black Studies for the first time organized a plenary session at its 1980 conference called "Black Studies and Women's Studies: Search for a Long-Overdue Partnership." There, a dialogue began suggesting that Black women's studies is gaining legitimacy within Black studies programs (Off Our Backs, 1982). The National Women's Studies Association has also made the curricular integration of minority women's lives and issues central to their annual convention activities and to their larger mission. As Black and women's studies programs make these ideological changes, we can anticipate the integration of minority women's health and other perspectives into the curriculum.

I conclude with some general and specific recommendations.

General Recommendations:

1) We need more research on the health needs of third world women, and wider dissemination of the results. Currently, many of the existing materials are found in conference proceedings or research reports. Some general information is found in ethnic studies journals, but none of these sources are widely available. We need to make them more available through library acquisition requests and through familiarizing our colleagues and our students with recent findings. Another rich resource in this area is minority women's fiction, which often contains valuable insights about health perspectives.

2) We need more summer training institutes and other such activities to provide curricular materials and to train those who teach health courses in both liberal arts and professional schools.

3) We need a national clearinghouse or journal for minority women's research and curriculum planning, in which health issues are given top priority.

Specific Recommendations:

4) With respect to individual campuses, we need to hire more third world women faculty.

5) We need to focus on minority women's issues in organized research activities. One way to encourage teaching about minority women is to push for research activity in that area on your campus.

6) Committees on curriculum development need to assure that courses on women are included in ethnic studies programs, that courses on minorities are part of women's studies programs and, above all, that multicultural and women's concerns are part of the general education curriculum. One model can be found in the 1983 article "Integrating Third World Women into the Women's Studies Curriculum" by Nancy Bazin, published in the journal Frontiers.

7) One of the criteria of evaluation for women's studies and ethnic studies programs should be the inclusion of minority women's concerns in courses. More importantly, one of the criteria for evaluation of the general education program should be the inclusion of ethnic and women's perspectives. If you sit on any review or evaluation boards on your campuses, you should make this an important issue.

8) On campuses where research is not supported, where the curriculum committee is not receptive, and where change is slow, informal campus networking should take place to make teaching materials and bibliographies available. As a first step, persons with access to information, like yourselves, could offer to give a supplementary lecture or provide a list of readings on minority

women's health perspectives. The next step, of course, would be reorganization of courses to include these materials as an integral part of the curriculum. There are many things that you can do if you are informed.

Finally, a positive note. As we consider the prospects for integrating minority women's health perspectives into the curriculum, we must consider the historical context. Remember the words of Gerda Lerner, who at a conference on integrating women's studies into the traditional curriculum said (I am elaborating): "How old are ethnic studies and women's studies? Less than twenty years old? How old is minority women's studies? Around five years old? We have to undo 6,000 years of cultural conditioning. Twenty years, five years, are nothing!" (Sitkoff, 1982:39).

Bibliography

Avakian, Arlene. "Women's Studies and Racism," New England Journal of Black Studies no. 1, 1981:31-36.

Avery, B.Y. E. Hinton Hoytt, P.E. Drake and J. M. Stewart (Eds.) Black Women's Health Issue. Spelman Messenger 100(1) 1984 (Spring):1-68.

Bazin, Nancy Topping. "Integrating Third World Women into the Women's Studies Curriculum," Frontiers, vol. VII, no. 2, 1983:13-17.

Cole, Johnetta and Monica Gordon. "Black Women as Colleagues in Black Studies," New England Journal of Black Studies no. 1, 1981:3-8.

Davidson, Douglas V. and Frederick S. Weaver. "Black Studies, White Studies, and Institutional Politics," Journal of Black Studies, vol. 15, no. 3, March, 1985:339-347.

Hull, Jennifer. "Black Studies/Women Studies: An Overdue Partnership," Off Our Backs, vol. 13, no. 6, June, 1983:5.

"'Keeping Black Women at the Center': A Conversation between Gloria T. Hull and Barbara Smith," Off Our Backs, vol. 12, no. 5, May, 1982:22-23.

Sitkoff, Harvard. "Restoring Blacks and Women to America's Past," Perspectives, vol. 14, no. 3, Fall, 1982:35-39.

Smith, Beverly. "Black Women's Health: Notes for a Course," In But Some of Us Are Brave, edited by Gloria Hull, Patricia Bell Scott and Barbara Smith. Old Westbury, NY: The Feminist Press, 1982.

Thomas, Charles. "Social Science Research and Some Implications for Afro-American Scholars," Journal of Black Studies vol. 15, no. 3, March, 1984:3250338.

Wellesley College Center for Research on Women, Research Report, vol. IV, no. 2, Spring 1985.

INTEGRATING MINORITY WOMEN'S HEALTH ISSUES INTO THE PROFESSIONAL SCHOOL CURRICULUM

Ruth E. Zambrana

Introduction

For close to twenty years a small but dedicated cadre of scholars has struggled to integrate minority health issues, and particularly minority women's health issues, into the curriculum in ways that are meaningful and sensitive. In this article I will examine some of the ways in which minority women's health issues need to be integrated into the curriculum of professional schools on three levels: first, in terms of the standard operational definition of health; second, how that definition relates to gender (women); and third, how these dimensions relate to interactions among gender, race and class.

Health has traditionally been defined as the absence of disease. Essentially, the medical or health field is still geared to curing disease and does not often emphasize the maintenance of health in its teaching institutions. Evidence of this is found in the curricula of medical schools, in the increasing trends toward specialization, and in the high prestige associated with highly technological medical fields such as brain and heart surgery. Community and family medicine, geared more towards health maintenance and wellness, are accorded little prestige and rank at the bottom of the status hierarchy. A contradiction emerges in that public health practitioners have demonstrated that up to 80-85% of all diseases are preventable given environmental changes and family education. Why then are most of the best paid practitioners and the largest number of resources channeled into curative, highly specialized, high technology medicine? This debate is old and worn, and the need for drastic changes is clear. The point here is that as long as the health system maintains its current organization women will continue to suffer indignities when they seek care (Fischer, 1986).

There is a recent but detailed and well documented history of how women have been treated or mistreated under the medical system because it is patriarchal, hierarchal and technological (Fee, 1983). Narratives have been recounted both by women as consumers (e.g. Boston Women's Health Collective, 1984) as well as providers (Harrison, 1982). In a study conducted at the University of California, Los Angeles, we attempted to obtain some insight into how physicians perceive patients of different racial/ethnic minority groups. In this study, 50 obstetricians were interviewed, including 13 attending physicians and 37 residents (18 males and 19 females). All of the women were residents. There were two major findings of interest. First, poor, racial/ethnic minorities were indeed perceived as difficult patients. Moreover, although social class was an important characteristic that influenced stereotypes, race was also critical. For example, white poor women were perceived as demanding. However, the combination of race and class generated the most negative stereotypes: Blacks were perceived as the most difficult patients of all (Zambrana, Mogel and Scrimshaw, 1983). This suggests that there is great social distance between provider and consumer which results in and/or is the result of cultural insensitivity. We can broadly define this as lack of knowledge of the groups involved and consequent lack of skills in interpersonal interactions. In a study conducted at Harvard, Good and Good (1986) found that social distance was a major barrier to successful provider-patient interaction. The important point the authors make is that all transactions occur across distinctive cultures and that professional status indicates participation in a distinctive subculture.

Issues in Modifying the Curriculum in Professional Schools:

A number of questions emerge with regard to modifying curricula to make them more sensitive to health issues of minority women. First, what types of materials do we integrate? Second, can faculty who are not knowledgeable on different racial/ethnic groups develop the capability to address and discuss such issues in a sensitive manner? That is, can we learn not only to discontinue perpetuating myths and stereotypes, but also to actually explain differences among ethnic minorities? Third, can the individual ground the problems in an historical and structural context and unravel the implications of these issues for policy directions, program development and service delivery? When attempts are made to present and discuss minority issues and these criteria are not met, potential impact is lost. Students depart thinking that these poor people are simply predetermined to be that way: they cannot and do not want to stop having children, they do not exercise, and they do not eat well, all because they do not want to. Stereotypes are simply reinforced.

To take up the first issue: what types of materials do we integrate? I do not believe that we should talk about integrating material into separate courses only, or into all courses as token materials. A general recognition that ethnic minorities have severe health problems which are related to their race, class and gender (both female and male) is necessary to guide education in professional schools. It has become clear in the last two decades that those students who know the most about ethnic minorities always attend the segregated courses and those who know the least carefully avoid them.

Thus when we talk about integrating minority women's health issues into a curriculum we are really talking about changing some of the basic premises of the ideology which is reproduced in the graduate school curricula. The medical model framework and its for-profit goal has created a health care system which provides differential care and stratifies the population by class, race and gender. In turn, these strata create many barriers within the system. Such historical and structural contexts must be presented in class to provide a framework for minority health issues.

Specific areas for inclusion in the curriculum need to be addressed and integrated on both the micro and macro levels. At the macro level, we need to begin with a number of premises. First, a major barrier we face in integrating minority health issues in specific areas is the lack of available data. In 1977, Virginia

Olesen in her book Women and Health: Research Implications for a New Era indicated that there was a serious deficit in data on women of color. Muller reasserted Olesen's conclusion in 1980 in her article "Women and Health Statistics" which appeared in Women and Health. Nonetheless, in the past ten years some initial work has been conducted which may be a useful starting point (e.g., USDHHS, 1985a and b; Jackson, 1981).

Second, we need to elucidate the institutionalized barriers in the system which are related to race, class and gender. These are reflected in the types of services available to working class women and women of color, such as county health services and hospital clinic services. Many of the women who use these services are either self-pay or are on Medicaid. The U.S. health care system has historically perpetuated a two-class system of care which keeps the different classes separate and maximizes profit. This system is managed primarily by white upper-middle class male professionals, even though the overwhelming majority of health care workers (about 80%) are women. Many professionals in this system do not recognize the importance of the provision of equal care for all. This differential care results in uneven and at times poor quality care to those who need it most.

Finally, the system is geared toward high technology and specialization, and is therefore not designed to address many of the issues of poor racial/ethnic minority groups. This has been documented not only in that the vast majority of health care problems require primary care intervention, but also in that many of the health problems of the poor and people of color (for example, diabetes, hypertension, and asthma) ultimately stem from socioeconomic conditions and stressors of everyday life.

Framework for Integration:

At the macro level we need to identify where minority individuals fit into the health system, and what are the characteristics and functions of the system's organization and financing which continue to place this population at a disadvantage in their use of health care services. This recognition needs to guide any integration of minority women's health issues into the curriculum.

On the micro level, I would suggest teaching a number of topics which include specific issues of minority women. For example, there are some preliminary data on the relationship between health status, race and class as well as on differential rates of morbidity and mortality (e.g., USDHHS, 1985a and b). There is also some beginning literature on chronic and acute disease, for example on hypertension among Blacks (e.g. H.D.F.P. Cooperative Group). Dr. Scrimshaw at UCLA has been conducting work on asthma and epilepsy among Latino children. Significant research is also beginning to emerge in the areas of the occupational health of racial/ethnic women (Mullings, 1984) as well as in the related area of the relationship between racial/ethnic women's multiple social/familial/economic roles and their health status.

For all women, the area of birthing is of critical importance. For women of color it represents an especially sensitive area in light of the historical treatment of women by the health care system as well as their particular oppression in terms of experimentation and sterilization. Women of color have experienced significant abuse not only based on gender but also based on race and class. The advantages that white middle class women gained as a result of the women's movement were in part gains related to economic position. These gains have rarely filtered down to the majority of women of color.

In most health care settings women of color still encounter professionals who are socially distant from them, who do not understand their needs, fears and cultural symbols, all within a system which puts them at psychological risk because of its insensitivities and new approaches to "efficiency." I was in an HMO hospital three years ago and shared a room with a woman who spoke no English and who had had twins. At this HMO the approach was self-help--you take care of yourself and your infants. However, because they were speaking different languages, this woman could not communicate her discomfort to the nurses. Language differences present serious barriers to care and translators are sorely needed.

In our study at UCLA there was another incident which illustrates a related point. Some Latinas believe that if their feet are cold their baby will die. One woman with this belief asked for a blanket, but the staff felt that because she was already in the delivery room the request was inappropriate. One can only imagine her panic that her child would die when her request was not granted. From this example we see the need to examine socio-cultural influences on the attitudes, values and mores of those who seek health care services. Psychological factors have been demonstrated to be related to better mother and child outcomes. This is a complex area, including factors such as social support, knowledge about birth and breastfeeding, attitudes towards pregnancy, and cultural expectations. We need to explain the importance of such factors to our students.

It is also important to assess the fertility rates of Latina and Black women and also the rates of infant morbidity and mortality. These data can be obtained from state and national vital statistics. The infant mortality rate for Blacks is still twice that of the general population (Jackson, 1981). Family planning and abortion are also critical areas to incorporate into the curriculum. There are a number of resources available which are very helpful, including the proceedings of a conference held in San Antonio, Texas, entitled "Latino Families in the U.S.: A Resourcebook for Family Education." Family planning is a sensitive issue for minority women because of the abuses that have occurred in the system, because of their own fears of contraceptives such as the pill, and their resistance to the use of messy methods such as the diaphragm. Furthermore, among low-income ethnic minorities, children represent a central dimension of their lives.

On the other hand, although fertility rates have declined in general among all women, Black and Latina women still have higher fertility rates. This is particularly notable in terms of adolescent pregnancy. Here again there is a need to examine differential rates by race and class in order to distinguish what are actually social problems versus cultural differences. Adolescent pregnancy among Blacks has historically been erroneously seen as pathological, and not a social problem. The issue becomes problemmatic because the limited options of poor racial/ethnic minorities are further limited by adolescent pregnancy in terms of educational and employment choices. Women with less education have always tended to marry at a younger age. For many, sources of social support such as economic help and child care resources are not readily available. In general, we know very little about sources of social support across groups (Vaux, 1986). However, we are beginning to see some new research in the area and some public schools have established programs which are geared to respond to the particular needs of pregnant adolescents.

Abortion is another area where there are significant knowledge gaps with regard to different class and racial/ethnic groups. There are many different points of view on the meaning of abortion. Depending on class, cultural values, situational context and so on, the decision to abort may be an easy or a difficult one; it is made or is not made. At this point we really do not know on what basis women from different racial and ethnic groups make these decisions. This area clearly warrants further investigation.

Finally, it is our responsibility as educators to present a model of health which fully addresses issues of differential care in the country, which recognizes the historical biases against women and individuals based on color and class status, and which stops perpetuating myths of equality and the melting pot (Zambrana, 1987). There is an unconscious ideology which has guided education in general and which is most obvious in higher education. The ideology is one which has placed a low value on racial/ethnic minorities, has been guided by the so-called "objective" world views of administrators and professors, and has denied the cultural diversity present in the U.S. There are important differences: upper middle class white women experience less discrimination than upper middle class Black women; poor white women experience a little less discrimination than poor Black women, and so forth. There is a rigid pyramid based on color, class and gender that is manifested in health, employment, housing and other areas of our lives. To integrate minority women's health issues into the curriculum without a basic understanding of the social structure and ideology in which they evolved is, at best, tokenism.

References:

Andrade, S. (Ed.) Latino Families in the United States: A Resource-book for Family Education. Educational Development, Planned Parenthood Federation of America.

Boston Women's Health Collective. Our Bodies, Our Selves. New York:
1984 Simon & Schuster.

Fee, E. (Ed.) Women and Health: The Politics of Sex in Medicine.
1983 Farmingdale, New York: Baywood.

Fischer, S. In the Patient's Best Interest: Women and the Politics
1986 of Medical Decisions. New Brunswick, New Jersey: Rutgers University Press.

Good, B. and M.J.D. Good. The cultural context of diagnosis and 1986 therapy: a view from medical anthropology. In M. Mirande and H. Kitano (Eds.), Mental Health Research in Minority Communities: Development of Culturally Sensitive Training Programs. USDHHS, NIMH., p. 1-28.

Harrison, M. A Woman in Residence. New York: Random House.
1982

H.D.F.P. Cooperative Group. Race, Education and Prevalence of
1977 Hypertension. American Journal of Epidemiology 106(5): 351-361.

Jackson, J.J. Urban Black Americans. In A. Harwood (Ed.) Ethnicity
1981 and Medical Care. Cambridge: Harvard University Press.

Muller, C. Women and health statistics. Women and Health, 4, (1),
1979 37-59.

Mullings, L. Minority women, work and health. In W. Chaukin (Ed.),
1984 Women's Health Hazards on the Job and at Home. New York: Monthly Review Press.

Olesen, V. (Ed.). Women and Their Health: Research Implications for
1977 A New Era. Springfield, Virginia: National Technical Information Service.

United States Department of Health and Human Services. Women's
1985a Health. Report of the Task Force on Women's Health Issues (Vol. II). Washington, D.C.

______ Black and Minority Health. Report of the Secretary's
1985b Task Force, Executive Summary (Vol. I). Washington, D.C.

Vaux, A. Variations in social support associated with gender,
1985 ethnicity and age. Journal of Social Issues, 41 (1), 89-110.

Zambrana, R. E., W. Mogel and S. Scrimshaw. Dynamics of the
1983 doctor-patient relationship: issues of gender, race and class in obstetrics. Unpublished paper presented November 14 at APHA, Dallas, Texas.

Zambrana, R. E. A research agenda on issues affecting poor and
1987 minority women: a model for understanding their health needs. Women and Health (forthcoming).

A CASE STUDY OF MINORITY CURRICULAR INTEGRATION: ASIAN/PACIFIC AMERICAN WOMEN'S HEALTH

Karen Ito

The biggest problem in integrating curricular materials on the health issues of Asian/Pacific American women is time. All too often I am asked, sometimes implored, to give a lecture during a course on women's health, medical anthropology, or women -- one lecture on Asian American women and health. (Rarely does anyone want Pacific Islanders included.) I also am told by these instructors how important it is that this area be covered: if I do not give the lecture, the instructor fears that the students will be deprived of vital information.

Several issues are raised by such lecture requests. First, how can I cover a collectivity of people which currently includes at least 29 different ethnic, cultural, national or regional groups? They are: Bangladeshi, Bhutanese, Burmese, Chamorro (native Guamanian), Chinese, Fujian, native Hawaiian, Hmong, Indian, Indonesian, Japanese, Kampuchean (Cambodian), Korean, Laotian, Malaysian, Micronesian, Nepalese, Okinawan, Pakistani, Filipino, Samoan, Singaporean, Sri Lankan, Tahitian, Taiwanese, Tibetan, Tongan, Thai, and Vietnamese. Of course, within these groups there are further distinctions, Taiwanese vs. Formosans, Tamils vs. Sinhalese in Sri Lanka, Hong Kong vs. Mainland Chinese, Western Samoan vs. American Samoan, and countless other regional, religious and ethnic subgroups.

It is important for faculty to explain this diversity to students: that the category of Asian/Pacific Americans represents a huge collectivity and that there is tremendous heterogeneity within the ethnic group. It is critical to take this in account to properly interpret statistics on Asian/Pacific Americans. This is obviously one of the most heterogenous minority groups, although as you know, not the only one. Native Americans and Hispanics confront the same complexities of diversity.

Among Asian/Pacific Americans, the three most populous groups, according to the 1980 census, are Chinese Americans (806,027), Filipino Americans (774,640) and Japanese Americans (700,747). Two of the most rapidly growing populations are the Koreans and Southeast Asians. The Korean population has increased over 400% from the 1970 to the 1980 census while the Southeast Asian population has increased from virtually zero to well over 360,000 people (1980 U.S. Census). [Some experts estimate a Southeast Asian population of over 900,000 (Rumbaut and Weeks, 1985; Rumbaut, et al., 1986)]. Most Asian/Pacific Americans live in the western states (59%), and most in California (36%). But they make up only 5% of California's population. Only 17% of Asian/Pacific Americans live in Hawaii, but they compose 60% of that state's population. In 1980, Asian/Pacific Americans numbered 3.7 million; nationally, they only represented 1.6% of the U.S. population (based on figures from 1980 U.S. Census). Yet this represents a 120% increase since the 1970 census and Asian/Pacific Americans have the largest percentage of of foreign-born individuals of any U.S. ethnic group (DHHS 1985b). Overall, 58% of Asian/Pacific Americans are foreign-born (DHHS 1985b), reflecting a tremendous influx of new immigrants since 1965.

Second, there is, however, a tremendous range of variation in the percentage of foreign-born within the different Asian/Pacific subgroups. For example, 70% of Japanese Americans are U.S. born, which is the reverse of the situation of the other major Asian/Pacific groups where most are foreign born. These other groups range from a high of 92% foreign born for Vietnamese to 62% for Chinese (Cheng 1984). This is important information when you are dealing with health education or clinical development materials. If, for example, you are trying to develop a health education program or an outreach program, or doing personnel planning for clinic staff, you must have some idea of the ethnic group you are targeting: what is the population like in terms of its variation, immigrant needs, dialects, political and religious preferences, and other such variables? It is inadequate and inappropriate to make assumptions based on broad-based generalizations.

Given these figures on the large numbers of foreign born Asian/Pacific Americans, it is very easy to forget that Asians have been in the United States for over 135 years officially and over 220 years unofficially. (Pacific Americans, of course, represent the indigenous populations in American Samoa and Guam.) Many people of Asian ancestry have been in this country for six or seven generations.

Third, some background information on the various early immigrant groups is important for curricular integration. The major Asian immigration began with Chinese in the mid-1880s. Early Asian immigrants were almost exlusively male and they were imported as labor for the agricultural fields in California and Hawaii. The major period of early Chinese immigration was from 1849 to 1882. In 1882, the first of many anti-Asian exclusion acts prevented the immigration of Chinese laborers and prohibited the naturalization of Chinese.

The immigration of women and the establishment of families differed tremendously among early pioneer Asian American groups -- Chinese, Japanese, Filipino. Early Chinese immigrants were often married in China and came over as sojourners, leaving their wives and sometimes unseen offspring in China, assuming they would someday return. Chinese wives of laborers were barred from entering the U.S. in 1884; in 1924, all Chinese ancestry women were barred from entering the U.S. Chinese Americans did not begin to establish families in the United States in any number until 1943, when the Exclusion Acts were repealed.

First generation Japanese American women emmigrated to the United States from 1900 until 1924. In 1924, immigration quotas were installed "excluding aliens ineligible for citizenship," and Japan was given a zero quota. Among this pre-1924 group were the well-known picture brides. Approximately 50% of the Japanese women immigrants from this period were estimated to be picture brides. These marriages were strictly regulated by the Japanese government. The women had to pass extensive physicals before leaving Japan and before entering the U.S. The men could not be any more than 13 years older than their prospective wives (they averaged 10 years older); they had to have a bank account and show the bank passbook to the Japanese embassy demonstrating that they had a certain annual income and had a specific minimal savings amount for so many months, depending on their occupation. The women were married in Japan, so they came to the U.S. as married women. The practice was voluntarily halted in 1919 by the Japanese government under pressure from the U.S. government. However, 43% of Japanese men in the U.S. were still unmarried; the Japanese male/female ratio was 6:4.

There was an interesting California law enacted in 1922 (the Cable Act) which tried to prevent American citizens from marrying those ineligible for citizenship. This act was primarily aimed at male Japanese aliens, who were barred from obtaining citizenship, and at the American citizens who might marry them. If an American woman did marry an alien ineligible for naturalization, the woman's citizenship was revoked. There is an interesting racial dimension to this: if you were white and your immigrant Japanese husband died or you divorced him, you would regain your citizenship; but if you were a woman of Asian ancestry, you would not (Osumi 1982). Laws such as this were passed to prevent the establishment of families and a second generation of U.S. citizens of Asian ancestry.

Filipino American immigration, like that of the Chinese and Japanese, began with men coming to the U.S. when they were young and single. The Filipino immigration period was primarily from 1924 until 1934. After 1934, legislation limited Filipino immigration to 50 people per year, despite the fact that Filipinos carried U.S. passports until Philippine independence in 1946. Prior to 1946, Filipinos (like present day Puerto Ricans and American Samoans) were U.S. nationals because the Philippines was an official U.S. territory. After independence, until 1965, the Philippines were limited to 100 immigrants a year.

The first generation Filipino community was central in challenging the early anti-miscengenation laws in California. In 1931 the State Supreme Court ruled that the anti-miscengenation law did not cover Filipinos because they were not "Mongolians" but "Malay." The California legislature then amended the law to include Malays. This remained so until 1948, when the State law prohibiting interracial marriages was declared unconstitutional by the State Supreme Court (Osumi 1982). But for most Filipinos this made little difference. The Filipino male/female ratio in 1940 was 7:1 (Osumi 1982) and most Filipino men from this early immigrant phase spent their entire lives as single migrant workers.

These early restrictive immigration and anti-miscengenation laws influenced the structure and the establishment of Asian American families. But for those Asian American women who were first generation wives and mothers, they pioneered lives quite different from their sisters and mothers in their homeland. For example, Chinese and Japanese women who were first generation wives were able to develop much more egalitarian marital relationships and more independence than they would have had in their homelands. One of the critical factors was the absence of a mother-in-law to dominate the household, as would have been the case in Japan or China. Also, many of the women were younger and healthier than their older, more weathered husbands. In small family businesses they became partners, working as a team in laundries and restaurants, or sometimes becoming the primary operator of the business (rooming houses, stores) while their husbands worked for a wage elsewhere (Glenn 1983, 1986). Such changes occurred quite early in Asian American history. In discussing the family and male-female relationships one must be careful not to assume a passive female and a dominant male as the Asian/Pacific American marital model (Howard 1974, Yanagisako 1985). There is considerable variation both within and across the different Asian/Pacific American groups.

After 1965, changes in the immigration laws brought a new wave of Asian/Pacific Americans who were largely well-educated and from upwardly mobile families. Many, such as Koreans and Filipinos, were very familiar with American culture and medicine through their countries' long association with the American military and U.S. corporations. These are the new laborers imported through the new immigration laws which favor relatives of U.S. citizens or permanent resident aliens and who fall into certain specified job categories. Early occupational priority was given to foreign-trained physicians and nurses. This is no longer the case. Another favored immigration category is refugee status, under which many Southeast Asians are able to enter.

There is a range of medical sophistication among these new Asian/Pacific immigrants -- from highly acculturated, medically and pharmacologically knowledegable urban Taiwanese and Koreans to the folk and herbal practices of Hmong and other rural Southeast Asian refugees. In some groups, such as among some Filipinos, there is the use of both Western medicine and faith healing. So again, we see that Asian/Pacific Americans are diverse and hard to characterize with generalizations.

How can one adequately discuss this diversity and still have time to make some meaningful statements about Asian/Pacific American health issues, Asian/Pacific American women's health issues or the role of women in health caretaking in a single lecture? This returns us to my original question. I have broadly outlined a few of the different family structures and challenged simplistic ideas of male dominance and female submission. But I have not described the plethora of health issues concerning Asian _and_ Pacific Americans.

What is the solution? This brings me to a second related question I ask when confronted by a request for a lecture on Asian/Pacific American women and health that is accompanied by the instructor's acknowledgement of the importance of this area to be covered: "Why haven't _you_ (the instructor) been doing it already if it is such an important topic?" _You_ can integrate ethnic health issues into your current course materials yourselves! Why treat ethnics as special cases? Get the articles and present them, use the materials and topics throughout your courses. When you give a section on the transmission of the hepatitis-B virus from pregnant, carrier-mothers to their offspring, include Asian/Pacific Americans and Black Americans. They, in fact, are more likely to be carriers than Caucasian Americans. When you discuss problems in perinatal care, cover the comparative statistics of whites vs. Blacks, Hispanics, Native Americans, Asians. It is a fascinating area of diversity.

When you talk about barriers to care, do not just treat such barriers from a homogenous, Caucasian American perspective. Deal with them from various perspectives -- majority and minority -- including the problems of language, doctor-patient relations, literacy, cultural etiologies, and so forth. We all know about the relationship of social support to health status. There is a great deal of material on the importance of ethnic differences in ways the family is organized in household structure, age differences, which individuals can be relied upon for mutual support, and its relationship to health status. Integrate these materials into your course!

When you discuss cancer, note that the highest incidence of cancer in this country is among native Hawaiians, for both males and females. Hawaiian women have the highest incidence of breast cancer of any group in this country, well over 100 per 100,000 (DHHS 1985a 2:113-118). What does this all mean? These are fascinating questions that would provoke excellent discussions and research topics for your students.

Importantly, this is not esoteric information that I found in obscure places. For example, the Department of Health and Human Services publishes materials on the health status of minorities. There are two excellent free publications that just came out in 1985 (DHHSa,b). They are full of detailed information and wonderful references, and they all should be available in health science libraries or the government publications sections of your campus library.

In other words, don't practice segregation in your curriculum. Start thinking about a comparative approach to your materials. Encourage cross-cultural perspectives through your own presentations. It is great that some of you do invite guest lecturers -- you should continue to do so and be encouraged to do so. But don't wait for guest lecturers to come and give a slice of ethnic life. You don't wait for oncologists to come to your class before you talk about cancer, and you don't wait for a domestic violence caseworker to talk about child or spousal abuse. There is no reason why you cannot discuss minority issues without minority lecturers and minority and Third World faculty. Also, we who are minority faculty need to stop being so parochial, focusing on only one or two minority groups. We have to broaden our own comparative perspectives. In other words, everybody should be developing much more comparative research analyses and curricula between and among ethnic groups.

A major problem in the integration of minority women's health issues is the lack of adequate data. The Department of Health and Human Services Task Force on Black and Hispanic Health found a dearth of ethnic data in the national and state statistical data banks. Problems such as inaccurate or nonstandard identification of ethnic group members, too-small samples collected for any meaningful statistical analysis, and "overaggregation of minority data" were cited by the Task Force as common problems (DHHS 1985b). In fact, they found it characteristic of the national data banks.

Because Asian/Pacific Americans do not exist statistically in large-scale data banks at the National Center for Health Statistics, and do not appear in ethnic breakdowns of health parameters or incidence, obtaining figures on Asian/Pacific American females is even more difficult. Other ethnic groups also face this problem, particularly Native Americans and Hispanics.

There has not been the continuous or consistent body of research on any one topic necessary to give more than a checkered picture of minority health status or health problems. Someone works on isolating a problem, publishes their data, and then the research drops from sight. For example, early work on differential rates of breast cancer between Japanese women in Japan, Hawaii and California was never followed up and all we are left with is an interesting little blip in the charts. Further, it is difficult to develop a coherent picture because of problems in research and sampling, or different time periods when the research was conducted, and so on. These data problems appear to be due to the absence of stable funding, the lack of a stable, tenured research faculty interested in minority research topics, and too-small national or state numbers for adequate aggregate reports. Such a lack of data on Asian/Pacific American health provoked the DHHS Task Force on Black and Minority Health to form a special advisory group to provide specialized data review and to commission ethnic-specific reports "to supplement inadequate national information" (DHHS 1985b).

Research funding is an obvious problem we all face, but Asian/Pacific Americans are often caught in a double bind: they seem relatively "problem-free" because their small numbers do not warrant more detailed analysis of within-group variability and, when aggregate statistics are available on mortality and longevity, they have quite good outcomes. So research funding is seen as less than pressing for this group. The double bind is "success" breeds "failure." The lack of research leaves many unanswered questions about what the aggregate data obscures in terms of the specific health profiles of the Asian/Pacific American groups. For example, research on native Hawaiians or Southeast Asians is beginning to show complexities that lie within the Asian/Pacific American conglomerate. Further, an additional research possibility that should not be ignored is that positive health models might be discovered in the sociocultural lifestyles of Asian and Pacific Americans.

We all know that many health problems originate in the context of poverty, family and community stresses, low education levels and in unemployment. The solutions are no longer seen as just biomedical. It is much more complex than that. We need innovative solutions and new ideas about health education, outreach, clinical treatment and etiologies in program and research development. Is there something we are overlooking because of our own assumptions? Is there something about the Asian/Pacific American sociocultural context that offers some clue as to what kinds of effective education, research, and prevention programs could be developed?

These are beginning to be recognized as important issues. The DHHS Task Force recommended (among many recommendations) that researchers should "Focus studies on the link between economic conditions and infant mortality, including sociocultural factors, that may help to explain the relatively good outcomes in infant mortality seen in the Asian, American Indian and the Alaskan Native populations" (1985:45). More research funds need to be sought so that minority research issues will be seen as important areas by the funding agencies. Furthermore, such arguments must appear more in the research literature, in courses and programs, and among students.

Another problem concerning data and research is that there are too few women and minorities in health sciences and too few who are senior faculty. This means that all too many of us, minority and non-minority women, are only in one place for a year or two. We cannot establish any program of research for students and/or other faculty. Many of us are faced with the personal difficulties of keeping afloat with temporary lectureships and soft money. This further erodes possibilities of developing funding for continuous, ongoing research. Until a community of scholars is established who contribute to a steadily growing body of research, teaching, and training on minority health and minority women's health, there can never be a base provided for good research, or program and curricular development.

What do you do? I would like to encourage you to help through your own courses and programmatic developments. First, make minority faculty and research in minority issues a priority. For example, there are a Asian Americans on faculties, trained in mainstream research topics who are not interested in minority issues and go in other directions. What is needed is not only the numbers of faculty, but the interest in research on minorities as well. Both minority and non-minority students also need to be encouraged to do research in this area. In other words, we need to develop the next generation of researchers who will provide us with the corpus of data to use in good curricular and program development. If you are covering comparative materials in your courses and programs -- it will be easy -- students automatically will be interested in it and want to get involved in a wide-open area full of promise and need. There is nothing more exciting than directing an enthusiastic student to such a topic area.

It is sometimes said that women are more flexible, innovative, and humanistic. If that is true, it would be good for us to use these strengths to develop programs and courses which are metaphors for what American society should be and not mere reflections of it. The health issues of minorities and Third World countries should be an integral part of mainstream curriculum and not treated as special cases set aside for isolated investigation. It is up to all of us -- but the burden is particularly heavy on those of you who are in a position to make changes and to influence the nature of research, clinical work, and program development through your institutions' programs and your own courses.

REFERENCES CITED

Cheng, Lucie.
1984 "The New Asian Immigrants in California." Paper presented to the Conference on Asia-Pacific Immigration to the United States, East-West Population Institute, Honolulu, Hawaii.

Department of Health and Human Services (DHHS).
1985a Health Status of Minorities and Low Income Groups. Second Edition. Washington, D.C.: U.S. Government Printing Office.

1985b Report of the Secretary's Task Force on Black and Minority Health. Volume I: Executive Summary. Washington, D.C.: U.S. Government Printing Office.

Glenn, Evelyn Nakano.
1983 Split Household, Small Producer and Dual Wage Earner: An Analysis of Chinese-American Family Strategies. Journal of Marriage and the Family 45(1):35-46.

1986 Issei, Nisei, War Bride: Three Generations of Japanese American Women in Domestic Service. Philadelphia: Temple University Press.

Howard, Alan.
1974 Ain't No Big Thing: Coping Strategies in a Hawaiian-American Community. Honolulu: University Press of Hawaii.

Osumi, Dick Megumi.
1982 "Asians and California's Anti-Miscengenation Laws." In Asian and Pacific American Experiences: Women's Perspectives. N. Tsychida, Ed. Pp. 1-37. General College, University of Minnesota.

Rumbaut, Ruben G. and John R. Weeks.
1985 "Fertility and Adaptation among Southeast Asian Refugees in the United States." Paper presented to the 13th Annual Psychosocial Workshop/Populaton Association of America. Boston, MA. (To appear forthcoming International Migration Review.)

Rumbaut, Ruben G. and John R. Weeks.
1986 The Politics of Migrant Health Care - A Comparative Study of Mexican Immigrants and Indochinese Refugees. In Research in the Sociology of Health Care, Volume 7. D.C. Wertz (Ed.) JAI Press.

Yanagisako, Sylvia J.
1985 Transforming the Past: Tradition and Kinship among Japanese Americans. Stanford: Stanford University Press.

IV. TEACHING WOMEN'S HEALTH AS HEALTH POLICY

SECTION INTRODUCTION

This section also emerges from our Summer Institutes and other teaching in women's health studies. Many women's health concerns are lively issues among health policymakers at both state and federal as well as international levels. Scholarly approaches to policymaking have long attempted to take into account the multiple perspectives of the various participants, concerned individuals and groups as well as direct beneficiaries. It is this comparative and integrative aspect of the approach which makes it an excellent lens through which to teach many issues in women's health.

Sheryl Ruzek has long used a policy framework to teach women's health. Here she discusses how she presents policy to resistant students and strategies for helping students to think in policy terms. Her outline of questions for student papers is also included.

Roberta Spalter-Roth's paper answers the question, "What is feminist social policy?" Her overview of teaching public policy from a feminist perspective both specifies elements of a feminist policy analysis and describes a program for training policymakers in women's interests. She also shares with us here an excellent teaching tool for women's health courses--her "Framework for a Feminist Analysis of Mainstream Public Policy Research."

A number of issues in women's health studies are controversial and hotly debated topics which can be challenging to teach despite deserving serious consideration in the curriculum. Teaching such topics through a policy framework is an effective strategy for managing such difficulties. Sheryl Ruzek provides us with her policy oriented strategies for teaching about abortion.

TEACHING WOMEN'S HEALTH WITH A POLICY ANALYSIS FRAMEWORK

Sheryl Ruzek

Teaching students to analyze women's health issues from a policy perspective requires us first to clarify what we mean by "policy." My experience is that students react to the term "policy" in the same way that they do to "theory" with fear, loathing, or at the very least some notion that this is something that happens far from their own realm. This view is especially prevalent among professional school students who see themselves as training to become practitioners of some sort, people who do not see themselves as "policy makers." Thus we must demystify policy and bring it into focus as something which is created and implemented at every level of society.

When I talk about policy, I try to reduce fear by talking about policy in the most mundane terms first. I say, "Don't just think about something that happens in Washington. Think about policies that exist in a clinic where you go and get health care. Or if you work in a health setting, what are the informal as well as the formal policies that you're faced with, and what are the consequences, sometimes extraordinary consequences of what look like itty-bitty tiny policies at local institutional levels?" After students see that they already understand some of these micro-policy issues, it is easier for them to approach more macro policy issues. We must also guide students to identify the specific level of policy which they will address be it federal legislation or service policy in a community agency with which they are affiliated. Finally, I find it useful to provide students with a series of questions about health issues or problems. These questions help them systematically consider many important issues which are at the heart of policy analysis.

To teach policy analysis, I ask students to write a term paper on a specific policy issue using an outline, "Health Program and Policy analysis Framework." (This outline follows these brief introductory notes.) In using the outline, I emphasize that some of the questions will be beyond the scope of most of their papers. However, I urge them to note that some of these questions will be critical to address if they in fact attempt to develop and implement policies. In particular, questions about the feasibility and conditions under which change in policy is possible or likely need to be taken into account. We discuss ways in which information on these topics can be located and used effectively in presenting proposals.

I have found that students' anxiety about writing policy papers decreases and the quality of their work increases when I use this teaching tool. I believe that it is effective largely because it clarifies precisely what I expect. And what I expect is not something terribly arcane or esoteric, but something which is fairly concrete and imaginable. Students readily see the usefulness of organizing many of the "things they already know" into a logically ordered presentation. They also can be encouraged to step back from an issue and reflect on the likelihood of stasis or change in an area of interest to them.

I have deliberately made this framework for analysis broad and general. It can be used to analyze many policy issues in health and social welfare. Because it is framed in such neutral language, it is especially useful in situations where faculty feel the need to adhere to expectations that course material will be "balanced" or "unbiased." In some courses such a framework could be used in class as a mechanism for discussing women's policy issues without labeling them as such. They can simply be used as examples of more general polcy issues. We all are familiar with how "men's issues" are used routinely to illustate general principles. We can easily use "women's issues" illustratively in whatever courses we teach.

Sheryl Ruzek, Ph.D., M.P.H.
Associate Professor
Department of Health Education
Temple University

HEALTH PROGRAM AND POLICY ANALYSIS FRAMEWORK

I. Background of the community health problem
   A. Who is affected?
   B. How many are affected?
   C. Who has identified this as a problem?
   D. Is this viewed as a growing problem, and if so why?

II. Proposed community program to deal with the health problem
   A. What are the goals and objectives of the program?
   B. What might the latent functions be?
   C. Who will benefit and/or be negatively affected by the program?

III. Basis for policy and/or program
   A. Scientific, professional research, professional principles of practice?
   B. Value Orientation of society, "experts"?
   C. Community action groups?

IV. Implementation Strategies
   A. To whom will proposed programs be provided or directed? (e.g. age, income level, sex, employment status)
   B. How will benefits, services be provided or eliminated?
   C. What specific types of benefits, services are involved?
   D. What type of institutions are or will be involved in implementing the program? (e.g. courts, HEW, welfare department, police, alternative service agency)
   E. How will the program actually work?

V. Feasibility
   A. What evidence is there of effectiveness? Cost-effectiveness?
   B. What sources of funds exist or could be developed?
   C. How high a priority is the policy or program to whom?
   D. What interest groups support or oppose the policy or program and why?
   E. What effect does the policy have on powerful interest groups?
   F. What would someone have to "give up" in order for a proposed change to be implemented?

VI. Conditions under which change in policy or program implementation is possible or unlikely
   A. General political conditions
   B. specific social-political-economic conditions
   C. Organized efforts by specific groups
   D. Specific changes in the wider social system

VII. Predicting Outcome
   A. What direction of stasis or change is likely over a given time period?
   B. Why will the direction you predict be likely? (summarize the structural and social psychological forces described above)

TEACHING PUBLIC POLICY FROM A FEMINIST PERSPECTIVE

Roberta Spalter-Roth

Since 1976, the George Washington University Women's Studies Program and Policy Center (WSPPC) has been concerned with linking women's studies programs to policymaking in women's interests. Since 1980, we have run the Congressional Fellowships on Women and Public Policy Program, along with the Women's Research and Education Institute of the Congressional Caucus on Women's Issues. Since 1983, the WSPPC has granted a Masters Degree in Public Policy with a concentration in Women's Studies as well as an M.A. degree in Women's Studies. We have always had an experiential learning/practicum/internship component to our program. In Fall, 1984, we began a new program sponsored by the Fund for the Improvement of Post-Secondary Education called "Training Women to Make Public Policy in Women's Interests: A Project Linking Women's Studies with Policy Institutions through Training and Experiential Learning."

This FIPSE-funded program has now been institutionalized as part of the WSPPC curriculum and is called "Applied Policy Research Opportunities" (APRO). One purpose of our M.A. program, as well as the APRO program, is to train women for the growing number of jobs in institutions whose primary mission is influencing, making or evaluating public policy. Many of these institutions deal with issues of great concern to different groups of women. Yet women are seriously underrepresented in policy making positions. Those who do hold policymaking jobs are often isolated and cut off from women's issues and women's networks. As a result of our experience in training women's studies students to become effective advocates for a wide variety of women's issues and groups, we have thought about what means and conditions are necessary to empower feminists to make public policy in women's interests.

This paper provides an overview of feminist policy concerns, new questions to guide a feminist policy agenda and methods for teaching public policy from a feminist perspective. First I discuss ways in which a feminist perspective adds to our understanding of the policy process. Second is an examination of some means of empowering feminists in policymaking. Last I briefly describe our APRO Program to train feminist policymakers.

What does a Feminist Perspective Add to Policy Analysis?

A central tenet of feminist analysis is the concept of the dual-vision -- the theory that historically oppressed groups not only know the dominant views of the society but also come to have an oppositional or critical view of those who have power and knowledge which they claim to exercise in the public interest. Feminist analysts are specifically interested in how men's (and especially ruling class men's) knowledge and interests are defined as universal knowledge and interests. The feminist critique of policy studies has been concerned with bringing women's interests into the center of the analysis and seeing how this inclusion changes the methods and outcomes of public policy.

The mainstream definition of public policy runs as follows: public policies are authoritative courses of action that are attempts to solve social problems in the public interest by control, regulations and/or distribution of social roles and economic resources with the government acting as either mediator or regulator between interest groups such as producers and consumers, workers and capitalists. The legitimate role of the state is seen as balancing or doing a cost-benefit analysis between different interest groups. Marxists would add that the state operates in the long-run interests of capital as a whole. Feminists would gender the definition by analyzing how the state works to perpetuate women's economic dependence on men and male domination.

The latest wave of the feminist movement has levelled a variety of criticisms at this definition and in addition has asked new questions. These criticisms include the following:

(1) Women and their concerns have tended to slip out of policymaking even when gender roles are key to the policy being debated. Often men and men's interests are used as the norm in making specific public policy.

(2) A paradoxical line of criticism is that public policy treats women, often dishonorably, as wives, mothers, or sex-objects rather than as workers or as heads of households or as equal individuals.

(3) Feminists join others in questioning to what extent policy is made in the public interest and, secondly, in depicting policymaking as a top-down, hierarchical process of centralized decision-making, using technical experts to arrive at technical rather than moral decisions. Feminists call on an alternative tradition of women philosophers and political scientists who define power not as hierarchical domination or a "thing word" but rather as a "capacity word" entailing notions of energy, competence, and mobilization of the community. Thus as feminists, we suggest that policymaking is a process consisting of many steps -- getting issues recognized, educating, lobbying, movement building, researching alternatives, and mobilizing constituencies as well as making decisions and implementing regulations. This process requires an understanding of social skills and social relations.

This critical feminist perspective leads to the asking of certain questions including:

(1) How does state policy, or any particular policy treat women? How are men kept in dominant positions? What are the underlying assumptions made about gender roles and relations, about the possibilities of changing these roles and relations?

(2) Who defines social problems, and to what extent are women seen as a social problem? To what extent is a social problem seen as due to the decline of traditional family, the decline of the public/private split and the decline in the "free work" done by women in the family?

(3) What are the relations between policymakers and those affected by the policy? This variant on the issue of research on women versus research for women asks, how do women's meanings and definitions become part of the policy discourse? Are women active in defining, organizing, developing, implementing and evaluating public policy? To what extent do social policies decrease class and race differences among women and decrease the notion that beneficiaries are incompetent dependents?

(4) To what extent do particular policies empower women -- give them control over resources, help them develop coalitions, bring them inside the policymaking process?

(5) How do different kinds of policy organizations fit into the process? How do these organizations build and choose issues and coalitions? How do they empower their constituencies?

(6) What kind of social skills and relations are critical for feminist involvement in the policymaking process?

These questions guide our analyses and development of policy at all levels.

What Have We Learned About Empowering Women in Policymaking?

Unlike traditional public administration definitions of policymaking as a hierarchical decision-making process of experts, our notions are based on both a moral vision as well as everyday experience. Based on this vision and based on our experience with these two programs, we have some notions about how to empower women, once they gain the possibility of access to the corridors of policymaking. Here are some maxims:

- Empowerment requires a sense of purpose about the importance of the work of developing public policy that benefits different groups of women.

- It is important to have a doubled vision that keeps you open to alternative modes of analysis, women's issues, knowledge rather than ideology, and the social, political, and economic contexts in which different groups enter the policymaking process. Power should be developed as capacitating, energizing, and mobilizing, not as domination. Redefining power in this way, however, should not blind us to relations of dominance around us and to the importance of having legitimate resources (like budgets) to mobilize.

- It is important to see the commonalities and differences between different groups of women and the varied issues that matter to them. Without this understanding, unexpected conflict and lack of support can occur.

- It is important to maintain and create social networks between women at all levels, not just peers or superiors, to avoid creating unnecessary hierarchies and to maintain relations with a variety of women's organizations, networks and coalitions. These groups often provide the marching millions that are crucial to get an issue recognized, a policy passed, a program implemented, or to keep you in your job.

- It is important to see that all policy work, like all knowledge, is a social production, not just the output of elites. Do not devalue the secretary or the B team as sources of definitions of the problem, modes of implementation and support.

- It is important to keep on with consciousness-raising groups to continuously learn and relearn how to deal with harrassment, chauvinism, ignorance, duplicity, the commonalities and differences between women, the structural characteristics of patriarchy, and to locate where the points of weakness are.

- We need to keep and bring about in others a sense of the importance of the struggle and the purpose of our mission to bring about greater equality and better lives.

- Access is important too. In this context, access is defined as the ability to influence those who make or implement policy. All the important legislation for women would not have been written without access. If one doesn't care if one gets credit, all sorts of ideas can be introduced by those who have access to policymakers. Without organization, the vast majority of women do not have access to power.

- To obtain power (the ability to mobilize, the capacity to innovate, create, carry-out), requires critical masses of women, not just a few at the top. As Carolyn Hood, a former Congressional Fellow and current director of the policy office at the American Association of University Women said in response to my question, what would it be like to have power? "If I could mobilize about 3,000 phone calls in a few hours when I need them."

The APRO Training Program: Policy in Women's Interests

On the basis of our experience running practicums, internships, and the Congressional Fellowship program, we were confident that we could create a program that also linked actual policymaking experiences with academic women's studies in a wider variety of policy institutions than Congress. Hence the program, "Training Women to Make Public Policy in Women's Interests" was born. We were particularly interested in preparing students for policy careers in trade, business, agriculture, education, labor, and health. Since 1970, there has been a 43 percent increase in these institutions and a 29 percent increase in local and state government. Yet again, despite the growth of women in managerial occupations over the last decade, we are still underrepresented in the decision-making positions of these organizations. The obvious result is that policy is seldom made with women's interests and needs in mind.

The purpose of the program is to empower women to make policy in women's interests. Several methods are used to do this. The first is to create a double vision in our students -- on the one hand, to develop the ability to use traditional policymaking skills and techniques, and on the other hand, to develop the ability to criticize the techniques and the assumptions on which they are based in order to provide alternatives to them.

The second method is to show feminists doing direct service work how to analyze the specific historical, social, economic and political relations that lead to particular kinds of direct service programs at particular times. The third method is to convince a broad range of policymaking organizations and university policy programs that feminist research and women's studies perspectives can enrich the process of understanding and making public policy.

To accomplish these goals, the FIPSE program has two major activities. These include a one-semester course titled, "Research Issues in Women's Studies: Applied Feminist Theory," and a one-semester hands-on policy internship experience in an agency or organization engaged in some aspect of the policy process on an issue of interest to women.

Students become aware of the following aspects of policy analysis in the first semester course: the language and method of public policy, policy research techniques, the history of specific social problems and attempts to solve them and differences between mainstream and feminist analyses of issues. In this course, students learn about the application of traditional research techniques, for example, how regression analysis is used to explain the lack of pay equity between men and women. But they also learn about attempts to create a feminist methodology that uses consciousness-raising techniques and the collective reconstruction of women's social experiences as women have lived them. Lived experience is at the center rather than at the periphery of analysis.

During the second semester course, students research and learn about the activities of policymaking institutions and the social skills and relations that are required in the policymaking process. (Under the APRO Program, we allow students with policy analysis or social science research backgrounds to wave the first semester course and only do the internship/practicum.) To this end, students are placed in a policymaking organization for an eight-week internship, attend a weekly practicum, and develop a research case study on the agenda setting and coalition and constituency building activities of the organization in which they intern. To analyze these activities, students ask questions about the organization through interviewing staff members, attending meetings, doing participant observation, gathering available documents and analyzing budgets and funding reports.

In its first year, the project placed students in settings where they worked on policy issues including the impact of child-support legislation, higher education and the training of female heads of household, childcare for school-age children, the impact of potential paycuts on federal employees, Social Security reform, international refugee problems, and the efficacy of programs designed to aid victimized women and children. In its second year, students worked on additional issues including: post-secondary school finance, daycare legislation, pay equity, problems in military families, and the impact of transportation deregulation. Currently, there is a demand for interns to work on issues including the effect of VCR's on women's health. Each year more interns are requested to work on a broader range of issues.

In addition to the two semester program, the project ran several policy panels designed to create additional networks among students, the university community, policymakers, researchers and analysts. These panels included "Conflicting Interests on Childcare," "A Feminist Perspective on International Immigration," and "Feminism and Economic Thinking: Beyond Benign Choice."

Conclusions:

In this paper, I gave an overview of the kinds of critical questions a feminist dual-vision asks of mainstream policy analysis and policy making. These questions focused on how women are either ignored or treated as dependent wives, mothers or sex-objects by public policy. The feminist critique also focuses on the hierarchical nature of the policy-making process.

In my view, asking critical questions is not enough for a feminist policy analysis. Therefore, in this paper I also suggested a redefinition of the policy process from a feminist perspective, and I described how the APRO program at the George Washington University trains women to take part in this process. It is my hope that this approach will be widely adopted not only in women's studies and women-oriented programs but also in mainstream policy programs. These mainstream programs especially need to examine their taken-for-granted assumptions of male dominance.

FRAMEWORK FOR A FEMINIST ANALYSIS OF MAINSTREAM PUBLIC POLICY RESEARCH

Roberta Spalter-Roth

Policy has been defined by mainstream analysts as authoritative (i.e. state legislated) courses of action that are attempts to solve social problems in the public interest by the control, regulation and/or distribution of social roles and economic resources with the state acting either as mediator or as regulator between interest groups. Policy research is defined as the process of conducting research on social problems in order to provide policymakers with recommendations for alleviating the problem.

As feminist policy researchers and analysts, we gender these definitions by determining how policy research or public policy is used to maintain male dominance and female dependence through factors including: biases in the research, gendered definitions of public and private roles, and the distribution of social and economic resources. We should also be concerned with how policy maintains class and race hierarchies and how those intertwine with gender hierarchies. We should pay particular attention to the extent to which policy research and public policy in its quest to solve social problems defines groups of women as the problem rather than empowering them to gain control over their lives.

The concerns of mainstream and feminist policy analysis are reflected on the two sides of the handout, A Feminist Analysis of the Perfect Policy Document. This handout is used as part of the exploration of a wide variety of feminist research issues and methodologies done in a required graduate women's studies course, "Research Issues in Women's Studies," at the George Washington University. To learn the techniques involved in what I have called "the dual-vision of feminist policy analysis," students are required to find appropriate documents for analysis--usually from a "blue-ribbon" commission, a government regulatory agency or a non-profit research and policy organization. Having obtained a document that meets with my approval, students write a paper answering both the mainstream and the feminist questions posed by the handout.

A FEMINIST ANALYSIS OF THE PERFECT POLICY DOCUMENT

Roberta Spalter-Roth

Policy documents are usually written during the agenda setting or formation stage of the policy process. The perfect policy document will include information and analysis concerning the statement of the problem, the socio-political-economic environment which causes the problem and/or constraints upon solutions to the problem, the design of the research or evidence-gathering methodology, the findings, and recommendations and methods for implementing the recommendations. For each of these categories a series of sub-topics in the form of questions are listed below. In addition, a series of questions about the document from a feminist perspective are listed next to the relevant category. In order to answer these two sets of questions, you will use the "double vision" that we are trying to develop.

I. Statement of the Problem

Policy Analysis	Feminist Analysis
1. How is the social problem(s) defined that the document addresses?	1. Does the definition of the problem and its key aspects fit into one of the feminist theoretical framework, i.e., liberal-feminist, socialist-feminist, or perspectives of women of color. Is the analysis of the problem a feminist analysis?
2. What model or causal analysis of the social problem is presented?	2. Is this a women's issue? Why or why not? Is there any feminist consciousness around the issue?
3. What values, ideology and assumptions are inherent in the analysis of the problem? Are they in conflict?	3. Are women identified as the problem or the cause of the problem or are gender relations seen as the problem?
4. What are the key issues or aspects of the problem that the document lists and addresses?	

II. Social, Economic and Political Environment

1. What's at stake? What distribution/redistribution of economic resources, of ownership, political power, control?	1. Are different groups of women identified as having a social, political or economic stake in the issue?
2. Who are the stakeholders that are identified (i.e. conflicting interest groups such as kinds of capitalists, political elites, minority groups, occupational groups, age cohorts)? Who are the important decisionmakers?	2. Are men or male dominated structures or organizations identified as the primary stakeholders and/or the important decisionmakers?

3. What is the impact of the problem on the different or conflicting interest groups (e.g. in terms of power, economic resources?

4. What, if any, analysis is presented of the resources available to the conflicting interest groups is presented?

5. What have been previous attempts to solve the problem? Why did they succeed or fail? What constraints are described to solving the problem?

6. Who are the authors of the document and what are their relationships to various interest groups? To whom is the document directed? Who funded it?

3. What role has the women's movement played in redefining the issue, changing the stakeholders, mobilizing new resources to attack the problem, gaining access or becoming the decisionmakers?

4. What, if any, feminist analysis of the social, political and economic environment of the problem is presented?

5. Which groups of women are the audience for the document? What are their relations to the policymakers?

III. Method for Gathering Evidence

1. What aspects of the problem are researched or studied? How? What is used as evidence (e.g. secondary analysis of previously collected data, synthesis of variety of types of evidence, surveys, anecdotes or testimony)? Is it a think piece or an empirical study?

2. What are the major concepts, how are they turned into variables, what measures are used?

3. Are the data used to make a case for the extent of the problem or for particular solutions? If so, how?

1. Does the research or evidence fit into the stages of feminist methods discussed in class?

2. Is the methodology, or parts of it, sexist? Is in "on" or "for" women?

3. Are women the focus of the research? Are they compared to men (on the same or different measures)? What is the relationship between the researcher and the researched?

IV. Findings and Recommendations

1. What findings are presented? Do they lead to particular recommendations? Are alternative interpretations of the data presented?

2. Which groups benefit from the recommendations? Which groups do not? Is any rationale given for differential benefits? How are potential conflicts to be mediated? What structural or organizational frameworks are suggested for implementing the recommendations?

1. Are the findings in women's interests? In some women's interests at the expense or others? If so is any rationale given?

2. Are the recommendations empowering for any groups of women? Are they given control over resources, if the recommendations are implemented?

(e.g. branch of government, private enterprise). What resources would they receive to do so?

4. Is there any analysis of intended and/or unintended effects of the recommendations, relations with other policies or programs? What would happen if the recommendations were not implemented?

3. Do the recommendations fit into any of the feminist frameworks presented in Jagger and Rothenberg?

4. What intended and/or unintended consequences would recommendations have for different groups of women? What would happen if they are not implemented?

V. Implementation

1. What are the means envisioned for implementing the recommendations -- what segment of government, private industry, volunteers, etc. will implement the recommendations and how?

2. Is the socio-political climate taken into account in making and implementing the recommendations?

3. What are the resources needed for the implementation of the recommendations, and where will they come from? Is there any cost/benefit analysis of the implementation of the recommendations?

4. What kinds of constituencies or coalitions are expected to support implementation of the recommendations and which are not? What resources are suggested as available to interest groups to implement or block the recommendations?

1. Do the strategies for implementation rely on women who are insiders or outsiders to the policy process? What relations between them are envisioned?

2. What strategies are suggested for developing constituencies or coalitions of women and women's groups, and are these empowering or coopting?

3. Will women's groups or women insiders be involved in implementing the recommendations?

4. Are the changes that will result from implementing the recommendations incremental or radical in terms of women's control over resources, power or in terms of equalizing gender relations?

Finally, evaluate the document in terms of the completeness and value of the analysis (both policy and feminist).

Feminist Policy Criteria

These criteria are to be added to, or incorporated with, the policy analysis framework you use to write up your policy brief.

A) The policy does away with the gendered public-private distinction, i.e.:

   1) does away with State policies that sustain beliefs in and the reality of a public-private split;

   2) does away with State policies to keep women doing activities in whatever is defined as the "private" sphere and men doing activities in whatever is defined as the "public" sphere;

   3) does away with assigning the provision of "love" to the private sphere, while assigning rational resource provision to the public sphere.

B) The policy expands women's economic self-sufficiency.

C) The policy breaks down the gender-based division of labor.

D) The policy decreases class-race differences among women.

E) The policy does not reinforce the notion that government beneficiaries are incapable, dependent and stupid while government professionals are competent and rational.

F) The policy helps break down the notion that participation in the policy process is limited to the iron triangle (politicians, producers and bureaucrats) and incorporates people (voters, consumers) who raised the issue to policy status.

G) The policy gives people more control over their own lives.

H) The policy supports people living in a variety of situations (e.g. traditional families, single-parent households, singles, groups, elders living alone or with others).

TEACHING SENSITIVE POLICY ISSUES: THE CASE OF ABORTION

Sheryl Ruzek

No topic is more sensitive or difficult to deal with in the classroom than abortion. Proponents and opponents of abortion are deeply commited to their positions. Students almost always are familiar with the basic stance of "pro-choice" and "right to life" groups, but they often know very little about the historical roots of the debate or facts about health issues surrounding legal and illegal abortion. In women's health studies, attention is appropriately directed towards the history and current legal status of abortion, the moral and ethical arguments, the emergence of movements involved in political action and policy-making, the social and psychological aspects of abortion, and the risks and benefits of various abortion techniques. While each of these aspects of abortion has a place in the curriculum, individual faculty will of necessity cover some in more detail than others. The choice of what to emphasize rests with the knowledge of the instructor, the values and constraints of each institution, and the focus of the overall course. In this paper I discuss some of the teaching strategies and materials which I find useful.

LINKING SENSITIVE ISSUES TO GOALS AND OBJECTIVES

I attempt to integrate abortion into a larger conceptual framework when I teach a full course on women's health issues. I believe that such a course can and should be more than just a "laundry list" of women's health issues, as important as each of those items on that list may be. As a medical sociologist--epidemiologist teaching in a department of health education, I attempt to use an interactionist perspective to examine women's health issues. One of the ways I convey this perspective is by presenting specific educational goals and objectives on the syllabus. I use language that the students can understand at least in part at the beginning of the term. By the end, they understand in a new way. Below are the objectives I use.

1. Provide students with an understanding of the socio-cultural contexts of women's health.

2. Prepare students to recognize the dynamics of race, class, and gender in health care.

3. Prepare students to assess the structural and social- psychological forces involved in a women's health across health issues.

4. Prepare students to assess underlying assumptions, values, and world-views which are essential to

discerning how meaning is attached to "data" on women's health issues. This perspective will prepare students to move towards being able to assess the needs of women from widely divergent backgrounds.

5. Provide students with basic qualitative research skills which are useful in clinical practice, applied research, and program planning, development and evaluation as well as basic academic research.

These objectives are very useful to have as a reference point because when we deal with sensitive issues such as abortion they allow us to diffuse some anger, hostility, and fear by focusing attention on the underlying or over-arching issues that cut across the whole array of women's health issues. Here I shall briefly describe how each of these objectives relates to abortion and give some examples which I find useful in the classroom.

My first objective, to provide students with an understanding of the socio-cultural context of women's health, is especially important to emphasize in teaching sensitive policy issues. In the case of abortion, we are addressing something which forms the context of women's lives. We have to look at the consequences for women when they do or do not have access to abortion. And we must look at the specific historical conditions under which abortion has been socially sanctioned or controlled by the state, the church, and the family.

The second objective, to prepare students to recognize the dynamics of race, class and gender in health and health care, extends our analysis of socio-cultural context. It opens up a whole array of complex issues ranging from the social distribution of unwanted pregnancies to the reasons women in different life circumstances feel the need to have--or not have--abortions. We also discuss conflicts of interest and perspective that grow out of race and class divisions. I have found that one of the most effective ways of doing this is to discuss what happened in 1972 when a group of poor, mostly black women were brought by bus from Chicago to Philadelphia to get second trimester abortions. (For details see Ruzek, 1978, pp. 198-204.) What had happened was that the abortion clinic in Chicago where the women were to have had abortions was shut down by the authorities. A women's group in Philadelphia attempted to provide abortions for these women. They couldn't get many people to help them, and eventually enlisted the help of Harvey Karman, the inventor of the Karman cannula, widely used in vacuum aspiration abortions. Karmen also had devised an experimental abortion technique, the supercoil abortion, in which large coils (like IUD's) are inserted to induce abortion. At the time, supercoil abortions had been used in Bangladesh to provide abortions for the large number of women who had been raped during war. The women were desperate and willing to do virtually anything to avoid carrying these pregnancies to term.

When the Chicago women's "emergency" came up in the United States, some of the women in Philadelphia felt that the circumstances justified the use of an experimental technique when it was offered at no cost. The women who came from Chicago by bus were exhausted and many were already in poor health. When a feminist group in Philadelphia learned that this "experiment" was going on, they were upset and concerned with quality of care. They came and pounded on the doors of the clinic where these abortions were taking place and tried to stop the experimentation. The accounts of what happened are phenomenally similar and different. But regardless of the differences in stories in Medical World News, Off Our Backs, and other feminist publications, what was clear was that these abortions were performed under the most horrendous conditions imaginable. The conditions in the clinic itself were poor; supplies were short; the women were in poor health, exhausted, and frightened. The people performing the abortions had flown in from California and were tired. And the people who perceived themselves as helping the Chicago women were now finding other women literally pounding at the door saying, "You're doing something bad, and we're going to stop it!" The District Attorney was called, legal authorities were brought in, and in the midst of this, not surprisingly, many of the women having supercoil abortions had very serious complications. Some women required hospitalization and major surgery.

In the aftermath of that event, feminists had to confront painful realities about quality control. The Chicago women pointed out that they didn't have any other options. They asked how feminists could tell them that these abortions were bad for them when it was the only abortion they could get. They angrily added that feminist supposedly know what it does to your life to have a child that you can't take care of and suggested that they were the ones who caused "the problem."

This is a concrete example of how we can begin to deal with the issue of conflicts of interest and definitions of situations which are rooted in race and class inequities. These are issues which are very hard for white, middle class feminists who truly believe in "choice" and "quality of care" to grapple with unless they have a concrete example to consider. I tend to be an inductive thinker and I always do better when I have a concrete example from which I can move upward conceptually. Some people think better deductively. I try to do some of both kinds of teaching in my classes because I know different people learn in different ways.

My third objective, to prepare students to assess the structural and social psychological forces involved in women's health across health issues, is critical. I underscore across health issues. The reason I put so much emphasis on this is that I fear that with the trend toward specialization, it is too easy for a student to say, "Gee, I know about domestic violence, rape and abortion, but I don't know anything about drugs or sexual harrassment or hazards in the workplace." When we get into policy arenas in particular we can become intimidated. What I try to cultivate in students is an ability to cut across the substantive issues and deal with the underlying social, psychological, and structural issues, so that they indeed can develop an informed opinion or perspective on virtually any women's health issue. I also want them to feel confident that they can approach the substantive literature to develop more expertise as needed. I do not want to train overly narrow technical specialists who become timid. Women tend to be timid anyway. It' hard to learn to overcome that timidity which can be reinforced in graduate training by the view that you can only talk about something if you are an expert in a field.

To actually teach students to see beyond specifics to general principles I try to draw parallels between seemingly dissimilar situations. I ask, "How is this situation similar to that?" So, for example, I try to use the supercoil abortion issue to draw parallels with certain features of other health issues. Once students have a grasp of the dynamics of race and class and choice in the case of supercoil abortions, they can more easily see what "choice" means in the case of sterilization and population control policy or as "protection" against reproductive hazards in the workplace. Then they can begin to really grasp the dimensions of choice given particular socio-political conditions.

This comparative approach works especially well with sensitive issues. In the case of abortion, I make a concerted effort to treat it like other health issues. This is partly an effort to normalize abortion as part of women's overall health experience and not treat it as something completely different. When abortion was almost totally illegal it was really set aside and not discussed openly. I have heard that even now when some people talk about abortion they lower their voices and feel the need to sound defferential. We feel we have to hedge in ways we wouldn't with other health issues. So I try to normalize abortion as a part of life. There are reasons to do that which are more then just political. If you look at the statistical data, you see what a large proportion of women face this as a life choice. If we look at the national statistics on how many women have had abortions and add women who didn't have abortions but were pregnant and thought about having abortions, we are talking about something that is really central to women's experience. And it comes up in so many areas of women's lives--from the regulation of sexuality to occupational issues to genetic screening. We need to talk about abortion in many courses and in relation to many substantive issues. As with race and racial minorities, we need to talk about them as we go along, as things come up, not just set off only as a single lecture or reading.

The fourth objective, to prepare students to assess the underlying assumptions, values, and world views which are essential to discerning how meaning is attached to data on women's health issues links into the fifth--learning to analyze qualitative data. We can get alot of data on how many of this and how many of that, but too often we really don't know what it means. To learn, we have to move beyond the false dichotomy between the value of quantitative data versus qualitative data. Many of us who were trained in graduate programs many years ago had to make a choice between being a "qualitative person" or a "quantitative person." When we get into women's health issues such as abortion, we clearly need both. We need quantitative data to know how many women get abortions, the social, economic and racial geographical distribution of abortion, and risk factors for complications. We also need qualitative studies that show us how women feel about abortions, how they feel about not being able to get abortions, and how they actually go about making decisions to have abortions. I am struck by how little we still know about so many aspects of abortion, particularly the underlying meanings and values. To understand meanings and values, we must listen very closely to women speak about theirexperience in their own voices. Our Bodies, Ourselves (1984) is probably still one of the best sources.

TEACHING SENSITIVE ISSUES FROM A FEMINIST PERSPECTIVE

I start from an assumption that all teaching is done from some perspective whether that perspective is openly acknowledged or not. We are all familiar with the unacknowledged white, male, middle-to-upper class, heterosexual perspective underlying most teaching. While we critique this openly, we are sometimes hesitant to teach openly from alternative perspectives, including feminist perspectives.

This raises an important issue, what is feminism? On the very first days of class I tell students that the course will be taught from a feminist perspective. This makes students sit up and listen. Somebody always asks, "What is feminism? What do you mean by that?' What is less often asked openly is "What's going to happen to me if I'm not one?" I have to deal with this fear even when it is not openly addressed.

To do this, we have to be clear about our own values and sense of fairness. I do not regard it my responsibility to provide a "balanced" perspective were such a thing even possible. Part of what women's studies is about is redresing the imbalances in the curriculum. What I do believe is necessary is to tell students what my perspective is at the outset. This is increasingly important to do because many students in women's courses now have not participated actively in the women's movements. They have not had their "consciousness raised." They do not know the language, the history, or the basic premises of contemporary feminism. They came of age sexually after abortion was legal.

To bring students into a discussion of feminism, I find Elizabeth Fee's classic article, "Women and Health Care: A Comparison of Theories" (1983) very useful. Fee describes liberal feminism, radical feminism, and Marxist-Socialist feminism very clearly. When I use it, I am struck by how students love it because it makes the world seem very clear. I am concerned that it oversimplifies and also needs updating. Nonetheless this article allows us to move into the reality that there are many women's movements, many feminist perspectives. My own recent article, "Femnist Visions of Health" in What Is Feminism edited by Juliet Mitchell and Ann Oakley (1986) attempts to elaborate this in very basic terms. I argue that we need to start with a simple "working definition" of feminism which is as broad and inclusive as possible. Thus I define feminism in the broadest sense as a world view which places women at the center of analysis and social action. It involves an ideological commitment to fostering the well-being of women both as individuals and as a social group in all spheres of life. But feminists themselves do not always agree on definitions of feminism, nor on the most salient problems facing women. Nor do feminists all agree on the strategies to follow to remedy problems. While all feminists involved in health activism are concerned with quality of care and women's experience of health, these terms themselves are open to multiple interpretations. Thus part of the task of the course becomes how to understand these sometimes conflicting definitions of feminism itself.

I tell students that they do not have to agree with any particular definition as a "good" personal or political ideology or theory. But to get through the course, they have to understand these ideas and be able to write about them as coherently as they would any other theory or concept. There is feminist scholarship and students are expected to learn what it presents. I tell them that I will not grade them on the basis of whether I agree or disagree with their views, but rather on how well they can identify and articulate a critical view of this scholarship. I do not want them to feel that they will be evaluated and graded on the basis of their agreement or disagreement with feminism per se. I also emphasize that they are expected to learn certain perspectives which contradict feminist perspectives.

When we get to the session focusing specifically on abortion, I make a point of saying, "In the discussion today, it would be a terrible error to start talking as though we all agree with one another, because the probability is very strong that we don't. So let's not offend each other by assuming that the other thinks the way we do." I also talk quite a bit about how my own views of abortion are related to where I stand in the social structure as a white, middle class, well-educated woman whose life chances are affected by access to abortion in certain ways. They will already have read Angela Davis' article on "Racism, Birth Control, and Reproductive Rights," (1983) which helps them contrast different views as grounded in different historical and socio-cultural circumstances. The supercoil abortions, discussed much earlier in the course, raise questions about "choice" which can now be elaborated further. If students become angry with each other (such arguments do sometimes break out) what I do is call a halt by saying, "Stop, stop" in a very loud voice. Then I say "Let's try to find out from each person's personal biography and where this person is located in social structures, why this person holds a particular point of view." The task, then, shifts away from any attempt on the part of students to convince others that their view is "right" or "wrong." Our job is to understand how someone else has come to have a value system different from our own.

KEY CONCEPTS AND ISSUES FOR TEACHING

I have already discussed race and class for teaching about abortion. Regional variation in both supply and demand for abortion is an important issue which brings in morals and values and informal as well as formal policies. The example of how abortion referral takes place within a fee for service system such as the United States, where abortion is rationed on ability to pay, compared to the British National Health Service, or other prepaid systems, where abortion is rationed on different criteria raises important issues. Sally Macintyre's book, Single and Pregnant (1977) provides qualitative data on how physicians hold moral judgments about which women do or do not "deserve" abortion. We can also consider the experience of abortion counselors who sometimes express anger at women who are repeat abortion-users. Carole Joffe's recent work, The Regulation of Sexuality (1986) addresses this issue sensitively. There are numerous conceptual frameworks within which abortion can be explored effectively. At the 1985 Summer Institute, Adele Clarke argued convincingly that abortion is best viewed in a larger reproductive health rights framework. She urged that we not look at abortion as an isolated issue but show how it is structurally, socially and psychologically linked to the regulation of female sexuality, the safety, efficacy, and availability of contraception, and to population control, sterilization, and genocide. Rosalind Petchesky (1985) suggests that feminists have viewed abortion too narrowly as a medical right, a decision between a woman and her doctor. She believes that we must move beyond seeing abortion primarily as a medical issue and treat it as a much broader health issue. She also argues that we have an obligation to deal with abortion as a moral issue. In Abortion and the Politics of Motherhood, Kristin Luker (1984) addresses moral issues directly and also provides insight into the "Pro-Life" perspective. Her book is an important contribution to our understanding of the complexity of their issues.

RESOURCE MATERIAL

For faculty who need basic background material on abortion, I highly recommend a brief article by Patricia Bayer Richard "Teaching about Abortion as a Public Issue" (1984). This article, combined with material from Our Bodies Ourselves (1984), will provide faculty who teach about abortion ideas for developing a sensitive approach to teaching abortion as part of a women's health course. The ACLU Speakers Manual on abortion written by Jean Hardisty (1982) provides a wealth of both factual information and suggestions for public speaking on this sensitive health issue. The ACLU also offers seminars on speaking on abortion effectively.

References

Boston Women's Health Book Collective. The New Our Bodies, Ourselves. New York: Simon and Schuster, 1984.

Davis, Angela (1983) "Racism, Birth Control and Reproductive Rights," in Angela Davis, Women, Race and Class. New York: Vintage.

Fee, Elizabeth (1983) "Women and Health Care: A Comparison of Theories," in Elizabeth Fee, Ed., Women and Health, The Politics of Health in Medicine. Farmingdale, N.Y.: Baywood Publishing Company.

Hardisty, Jean (1982) ACLU Speakers Manual on Abortion. Chicago: ACLU Reproductive Rights Projects, 220 South State Street, Suite 816, Chicago, Illinois 60604

Joffe, Carole (1986) The Regulation of Sexuality. Experience of Family Planning Workers. Philadelphia: Temple University Press.

Luker, Kristin (1984) Abortion and the Politics of Motherhood. Berkeley: University of California Press.

Petchesky, Rosalind Pollack (1985) "Abortion in the 1980's: Feminist Morality and Women's Health," in Ellen Lewin and Virginia Olesen, Eds., Women, Health, and Healing, Toward a New Perspective. New York: Tavistock Publications.

Richard, Patricia Bayer (1984) Women's Studies Quarterly, Winter.

Ruzek, Sheryl (1986) "Feminist Visions of Health: An International Perspective," in Juliet Mitchel and Ann Oakley, Eds., What is Feminism? London: Basil Blackwell.
Ruzek, Sheryl Burt (1978) The Women's Health Movement, Feminist Alternatives to Medical Control. New York: Praeger.

V. RESOURCES FOR TEACHING WOMEN, HEALTH AND HEALING

A. RESOURCES FOCUSED ON MINORITY WOMEN'S HEALTH

SECTION INTRODUCTION

One of our major goals in curriculum development in women's health studies is the integration of minority women's health issues and materials into courses at all post-secondary levels. These resources are designed to help meet this goal.

The two-page BASIC BIBLIOGRAPHY ON MINORITY WOMEN, HEALTH AND HEALING IN THE U.S. is an excellent place to begin such efforts. It contains what we believe to be the strongest and most basic yet thorough works we found in developing our major 120-page bibliography. The listing of SELECTED EDUCATIONAL RESOURCES ON WOMEN OF COLOR developed by SAGE can direct you to local and regional resources, specific research centers and a variety of special projects and organizational efforts.

One of the most powerful ways to teach about minority women's health is through the use of audio-visual materials. Our list of such materials is organized into sections on race/class/culture issues with health implications, aging, women's health care politics, childbirth education in cultural contexts, occupational health, minority women as providers of health care, reproductive health issues, self-image/body image issues and violence against women. While some of these audiovisual materials focus exclusively on minority women, most jointly include minority and white women and their health concerns.

We also offer here two resources focused specifically on Black women's health. The HEALTH FACT SHEET ON BLACK WOMEN developed by the National Black Women's Health Project can be used as a class handout for discussion. Audreye Johnson's syllabus on AFRICAN-AMERICAN WOMEN'S HEALTH ISSUES is one of a handful of such courses in the U.S. at this time and is an excellent curricular model of a course focused on a specific minority group. [See also Beverly Smith. Black Women's Health: Notes for a Course. In G. Hull, P. Scott and B. Smith (Eds.) But Some of Us Were Brave: Black Women's Studies. Old Westbury, NY: The Feminist Press, 1982.)

Had we been successful in locating syllabi, fact sheets or similar materials on the health of women of other minority groups, we would have included them here. However, in our SYLLABI SET ON WOMEN, HEALTH AND HEALING: 14 COURSES, there is a syllabus for Soc. 134 (Fall, 1986 version) that is devoted to comparative perspectives on the health issues of minority women in the U.S. Our MINORITY WOMEN, HEALTH AND HEALING: SELECTED BIBLIOGRAPHY AND RESOURCES can be used to focus curriculum development on particular aspects of minority women's health either comparatively or focused on a particular group.

The Center for Research on Women at Memphis State University has developed a number of valuable resources on women of color and women's health. We provide here information about and forms to use their ambitious Women of Color and Southern Women Reference Database.

UCSF WOMEN, HEALTH AND HEALING PROGRAM

MINORITY WOMEN, HEALTH AND HEALING IN THE U.S.: BASIC BIBLIOGRAPHY

Compiled by Sheryl Ruzek, Patricia Anderson, Adele Clarke, Virginia Olesen and Kristin Hill, Women, Health and Healing Program, N-631-Y, University of California, San Francisco, CA 94143-0612. The following references were selected to help you locate important sources on minority women's health. These selections are overviews of major issues, bibliographies or reference works from our longer bibliography (order form on reverse).

Comparative, Overview and Reference Works

United States Department of Health and Human Services. (1985). Special health concerns of ethnic minority women. In Women's Health, Report of the Public Health Service Task Force on Women's Health Issues, (II), pp. II-37-47. DHHS Pub. No. (PHS) 85-50206.

United States Department of Health and Human Services. (1985, August). Report of the Secretary's Task Force on black and minority health. (I), Executive Summary. U.S. Government Printing Office, Washington, D.C. 20402.

Mullings, L. (1984). Minority women, work and health. In W. Chavkin (Ed.) Double exposure: Women's health hazards on the job and at home. New York: Monthly Review Press.

Wilkinson, D. (1980). Minority women: Social-cultural issues. In M. A. Brodsky & R. Haremustin (Eds.) Women and psychotherapy, pp. 285-304. New York: Guilford Press.

Shea, S. & Fullilove, M. T. (1985, October 10). Entry of black and other minority students into U.S. medical schools: Historical perspective and recent trends. New England Journal of Medicine, 313(15), 933-940.

Hine, D. C. (1982). From hospital to college: Black nurse leaders and the rise of collegiate nursing schools. Journal of Negro Education, 51(3), 222-237.

Afro-American Women's Health

Simms, M. C. & Malveaux, J. M. (Eds.) (1986). Slipping through the cracks: The status of black women. New Brunswick, New Jersey: Transaction Books.

Avery, B. Y., Hinton-Hoytt, E., Drake, P. E. & Stewart, J. M. (Eds.) (1984, Spring). Black women's health issues. Spelman Messenger, 100(1), 1-68.

Royster, J. J. (Curator). (1983). Women as healers, a noble tradition. Women's Research and Resource Center, Spelman College, Box 362, 350 Spelman College Lane, S.W., Atlanta, GA 30314. $6.00.

Bell-Scott, P. & Guy-Sheftall, B. (Eds.) (1985, Fall). Special issue: Health. Sage: A Scholarly Journal on Black Women, II(2), 2-78.

Asian American Women's Health

Theim, T. M. (1979, May 8-9). Health issues affecting Asian/Pacific American women. In *Civil rights issues of Asian and Pacific Americans: Myths and realities*. Proceedings of the Conference. Washington, D.C.

Ito, K. L. (1982). Illness as retribution: A cultural form of self analysis among urban Hawaiian women. *Culture, Medicine and Psychiatry*, *6*, 385-403.

Hessler, R. M., Nolan, M. F., Ogbru, B. & New, P. K. (1975, Fall). Intraethnic diversity: Health care of the Chinese-Americans. *Human Organization*, *34*(3), 253-262.

Davidson, L. (1981, May). Women refugees: Special needs and programs. *Journal of Refugee Resettlement*, *1*, 16-26.

Latina American Women's Health

Zambrana, R. E. (Ed.) (1982). *Work, family and health: Latina women in transition*. Available from Hispanic Research Center, Fordham University, Bronx, New York 10458. $10.

Melville, M. B. (1980). *Twice a minority: Mexican American women*. St Louis: C. V. Mosby Co.

Becerra, R. W., Karno, M. & Escoban, J. I. (Eds.) (1982). *Mental health and Hispanic Americans: Clinical perspectives*. New York: Grune and Stratton.

Martinez, R. A. (Ed.) (1978). *Hispanic culture and health care: Fact, fiction, folklore*. St Louis: The C. V. Mosby Company.

Native American Women's Health

Wood, R. (1980, October). Health problems facing American Indian women. In *Conference on the educational and occupational needs of American Indian women*, pp. 159-183. Washington, D.C.: National Institute of Education.

Kelso, D. R. & Attneave, C. L. (1981). *Bibliography of North American Indian Mental Health*. Westport, Connecticut: Greenwood Press.

United States Department of Health, Education and Welfare. (1978). *Indian health trends and services*. Washington, D.C.: Department of Health, Education and Welfare Publication No. (HSA) 78-12009.

Kidwell, C. S. (1979). American Indian women: Problems in communicating a cultural/sexual identity. *The Creative Woman*, *2*, 33-38.

UCSF

CURRICULAR MATERIALS IN WOMEN'S HEALTH

______ Minority Bibliography $7.00
______ Teaching Materials $7.00
______ Syllabi Set $10.00
______ Set of all three $20.00

All materials will be available by December 1, 1986. Payment must accompany order. Please make check payable to Women, Health and Healing Program and send to Women, Health and Healing Program, Department of Social and Behavioral Sciences, N-631-Y, UCSF, San Francisco, CA 94143-061

Ship to: Name ______________________ Phone # ______________
Address ____
____

SELECTED EDUCATIONAL RESOURCES ON WOMEN OF COLOR

RESEARCH AND RESOURCE CENTERS

Bethune Museum-Archives National Historical Site
1318 Vermont Ave., NW
Washington, D.C. 20005

Black Careers Women's Center
706 Walnut St., Suite 804
Cincinnati, OH 45202

Center for Research on Women
Memphis State University
Memphis, TN 38152

Center for the Study, Education and Advancement of Women
University of California at Berkeley
Berkeley, CA 94720

Center for Women's Identity Studies
Chicago State University
95th & King Dr.
Chicago, IL 60628

Council on Interracial Books for Children
1841 Broadway Ave.
New York, NY 10025

OHOYO Resource Center for American Indian and Alaska Natives
National Women's Program Development
2301 Midwestern Parkway, Suite 214
Wichita Falls, TX 76308

Minority Women's Program
Wellesley College Center for Research on Women
Wellesley, MA 02181

Moorland-Spingarn Research Center
Howard University
Washington, D.C. 20059

National Council of Negro Women, Women's Center
Suite 201, 198 Broadway Ave.
New York, NY 10038

National Institute for Women of Color
1712 N. St., NW
Washington, D.C. 20036

Women's Resource Center
Aguedilla Regional College
University of Puerto Rico
Box 160
Ramey, PR 00604

Women's Institute of the Southeast
c/o Africana Women's Studies Project
Atlanta University
642 Beckwith Street
Atlanta, GA 30314

Women's Research and Resource Center
Spelman College
Atlanta, GA 30314

PUBLISHERS

Afro-Resources, Inc.
P.O. Box 192
Temple Hills, MD 20748

Aware: Research Journal by and about African Women
Anthony Associates, Inc.
2622 Georgia Avenue, N.W.
Washington, D.C. 20001

Black World Foundation
P.O. Box 908
Sausalito, CA 94965

Conditions
P.O. Box 56
Van Brunt Station
Brooklyn, NY 11215

The Feminist Press
Box 334
Old Westbury, NY 15568

Kitchen Table Women of Color Press
Box 592
Van Brunt Station
Brooklyn, NY 11215

The Naiad Press, Inc.
P.O. Box 10543
Tallahassee, FL 32302

Sage Women's Educational Press, Inc.
P.O. Box 42741
Atlanta, GA 30311

Women Educational Equity Act Publishing Center
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02160

Women's International Resource Exchange
2700 Broadway
New York, NY 10025

SPECIAL PROJECTS AND ORGANIZATIONAL EFFORTS

African-American Family History Association
2077 Bent Creek Way, SW
Atlanta, GA 30311
Contact Carole Merritt

Africana Women's Studies Project
Atlanta University
Atlanta, GA 30314
Contact Eleanor Hinton Hoytt and Shelby Lewis

Black Studies/Women's Studies Curriculum
Integration Project
English Department
University of Massachusetts
Amherst, MA 01003
Contact Margot Culley

Black Women and the Church Project
Interdominational Theological Center
Atlanta, GA 30314
Contact Jacquelyn Grant

Black Women in the Mid-West Project
Purdue University
Department of History
University Hall
West Lafayette, IN 47907
Contact Darlene Clark Hine

Black Women's Health Project
Martin Luther King, Jr. Community Center
450 Auburn Ave., NE, Suite 157
Atlanta, GA 30312
Contact Byllye Y. Avery

Black Women's History Project
c/o Association of Black Women Historians
Purdue University
West Lafayette, IN 47907
Contact Darlene Clark Hine

Black Women's Studies Faculty and Curriculum
Development Project
Wellesley College Center for Research on Women
Wellesley, MA 02181
Contact: Margo E. Bradford, Coordinator
Gloria T. Hull, Patricia Bell-Scott & Barbara Smith,
Co-Directors

Black Women's Studies Faculty and Curriculum
Development Project
Spelman College Women's Research and Resource Center
Atlanta, GA 30314
Contact Beverly Guy-Sheftall

Chinese American Women Educational Equity Program
Organization of Chinese American Women
956 N. Monroe Street
Arlington, VA 22201
Contact: Lotte Chi, Yowkeum Chung, and Pauline Tsui

Contemporary American Indian Women Project
Minnesota Chippewa Tribe
P.O. Box 217
Cass Lake, MN 56633
Contact Patricia Bellanger

International Council of African Women
P.O. Box 8676
Washington, D.C. 20011

Multicultural Women's Studies Program
University of Illinois at Chicago Circle
P.O. Box 4348
Chicago, IL 60680
Contact Margaret Strobel

National Network of Minority Women in Science
American Association for the Advancement of Science
1776 Massachusetts Ave., NW
Washington, D.C. 20036
Contact Paula Quick Hall and Shirley Malcom

Promoting Career Development Opportunities for
Single Parent Minority Women
85 Greenbriar Street
Dorchester, MA 02124
Contact Mary L. Reed

Research in Counseling for Puerto Rican Women
Inter-American University
GPO Box 3255
San Juan, PR 00919
Contact Rosa Santiago-Marazzi

Sistervisions: Black Women Artists Film Series
14 Beacon Street
Boston, MA 02120
Contact Beverly Smith

Southern Black Women's Culture Project
Women's Studies Program
University of Alabama
University, Alabama 35486

Mexican American Women Curriculum Project
1100 E. 8th Street
Austin, TX 78702
Contact Martha Cotera

Women of Color Curriculum Development Project
Urban Affairs Department
St. Paul Public Schools
St. Paul, MN 55102
Contact Gloria L. Kumagai

© Copyright, 1984 Sage Women's Educational Press, Inc.

(reprinted with permission from SAGE)

THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

School of Social Work

Course Number: SOWO 387-47

Course Title: African-American Women's Health Issues

Instructor: Audreye E. Johnson, Ph.D.

Semester: Fall 1986

Course Description: Women are faced with similar, but also differing health problems. An exploration of selected health issues confronting African-American Women identifies race, gender, and class variables which impact health.

Course Objectives:

1. To become familiar with the bio-psycho-social indices which influence wellness and sickness.
2. To develop self-awareness of socialization and control processes which determine management/treatment of health problems.
3. To become familiar with service delivery with a clientale impacted by race, gender, and class interlocking and interfacing primary, secondary, or tertiary care.
4. To demonstrate understanding of the barriers to health, and willingness to seek creative means of redress and service.

Course Requirements:

1. Class attendance and active student participation in class is expected.
2. Students will use the readings in oral and written reports, citing appropriate examples.
3. Students will demonstrate the connection between the course and social work services or social welfare policies.
4. Students will demonstrate their skill development in working with the population, and ways of reducing barriers to service delivery.

Evaluation of Student

Students are expected to meet all course requirements. Students will be graded upon knowledge acquired and skill developed as evidenced by class participation, oral reports, and written assignments.

20% - Class participation and oral reports. Students are expected to contribute to self-learning and that of fellow students and faculty: share readings, ideas, or resources.

20% - Paper related to an issue and the health of Black Women. (5 pages in length) Due the fifth week of class. Typed double spaced with footnotes and bibliography.

20% - Paper related to a health problem and the securing of needed service in the social welfare arena (5 pages in length). Due at mid-term. Typed double spaced with footnotes and bibliography.

40% - Final written assignment due the last day of class. Students will indicate in writing the topic choice the week after mid-term. This assignment should reflect the student's interest in a health issue related to servie delivery on the direct or indirect level.

There are options to the completion of this assignment. An individual or group term paper, a project (field observation of barriers to service), etc. These examples are illustrative and are not inclusive of options open to students. Regardless of the option selected, students will utilize readings in their final assignment with appropriate footnote and bibliographical documentation. Approximate length of paper 16 pages including referenced footnotes and bibliography.

Students should use Kate Turabian as a source for writing style, footnotes, and bibliography. All papers should be typed and double spaced, see Turabian on format. All racial designation are to be capitalized, i.e., Black, White, Negro, Chicano, Asian, Native American, Indian, Hispanic, etc.

A grade of incomplete will be given to students who do not complete the minimum course requirements.

The final grade will be based upon the above assignments.

Conferences may be scheduled by appointment.

Students will return all loaned materials (unmarked) at least one week before the end of the semester. The usual loan period for items will be two weeks. Extensions may be granted provided other students do not request the item on loan. Students are responsible for replacement of any lost items.

Certain readings are called to the attention of the students, however, it is expected that students will select other readings to enhance their knowledge building and professional development.

Readings:

There is currently no single text which addresses the substantive issues of this course. There are a number of books and articles which have related materials which should be useful in knowledge building. Additionally, it is hoped that students will seek out readings which will enhance their own as well as the knowledge base of the entire class. An asterisk donates some of the necessary readings.

Format - Seminar:

Student participation and involvement is expected and encouraged. In addition to the exchange of ideas, the seminar will be used to conceptualize practice methods which will enhance the delivery of social work service to African-American women. The course will be taught in module sections.

Module I: The Cultural Context of African-American Women's Health

A. Race, Gender, and Class

B. Belief System

C. Folk Medicine

D. Modern Medicine

E. Self-Help

Readings:

* The Boston Women's Health Book Collective. The New Our Bodies Our Selves: A Book By and For Women. New York: Simon and Schuster, Inc., 1984. Preface and Introduction, and Earlier Prefaces. Chapter 1 Taking Care of Ourselves, section 1, 5, 7, and 8. Chapter VI, Some Common and Uncommon Health and Medical Problems.

Dill, Bonnie T. "The Dialectics of Black Womanhood", Signs, Spring 1979, pp. 543-555.

Gilkes, Cheryl Townsend, "From Slavery to Social Welfare: Racism and the Control of Black Women", In Amy Swerdlow and Hannah Lessinger (eds) Class, Race, and Gender: The Dynamics of Control. Boston: G. K. Hall, 1983.

* Rogers-Rose, LaFrances (ed) The Black Woman. Beverly Hills, CA.: Sage Pbulications, 1980.

Wilkinson, Doris. "Afro-American Women and Their Families", Marriage and Family Review, Fall/Winter 1984, pp. 125-142.

Wilkinson, Doris. "Minority Women: Social-Cultural Issues" in A. Brodsky and R. Hare-Mustin (eds.) Women and Psychotherapy: An Assessment of Research Practice. New York: Guilford Press, 1980.

Lerner, Gerda. Black Women in White America: A Documentary History. New York: Pantheon Books, 1972.

Stellman, Jeanne M. Women's Work, Women's Health: Myths and Realities. New York: Pantheon Books, 1977.

* Watkins, Elizabeth L. and Audreye E. Johnson. Removing Cultural and Ethnic Barriers to Health Care. Chapel Hill, N. C.: Schools of Public Health and Social Work, University of North Carolina at Chapel Hill, 1985.

* Williams, Richard A. Textbook of Black Related Diseases. New York: McGraw-Hill, 1975.

* Rudov, M. H. and N. Santangelo. Health Status of Minorities and Low Income Groups. Washington, D.C.: U. S. Department of Health, Education, and Welfare, Government Printing Office, 1979.

* U. S. Department of Commerce. The Social and Economic Status of the Black Population in the United States: An Historical View, 1790-1978. Washington, D. C.: Bureau of the Census, Government Printing Office, 1979.

Gary, Lawrence E. Mental Health: A Challenge to the Black Community. Philadelphia: Dorrance and Company, 1978.

* Gary, Lawrence E. "The Health Status of Black Americans", in Audreye E. Johnson (ed.) The Black Experience: Social, Cultural, and Economic Considerations. Chapel Hill, N. C.: School of Social Work, University of North Carolina at Chapel Hill, 1981.

Jackson, Jacquelyn Johnson, "Black Women in a Racist Society", in Charles V. Willie, et al. Racism and Mental Health. Pittsburgh: University of Pittsburgh Press, 1973.

Dill, Bonnie Thornton, "Race, Class, and Gender: Prospects for An All-Inclusive Sisterhood", Feminist Studies, Spring 1983.

* Palmer, Phyllis Marynick, "White Women/Black Women: The Dualism of Female Identity and Experience in the United States", Feminist Studies, Spring 1983.

Dill, Bonnie Thornton, "On the Hem of Life: Race, Class, and the Prospects for Sisterhood (1980)", in Amy Swerdlow and Hannah Lessinger (eds.) Class, Race, and Gender: The Dynamics of Control. Boston: G. K. Hall, 1983.

Davis, Angela Y. Women, Race, and Class. New York: Random House, 1981.

Hull, Gloria T. Patricia Bell Scott, and Barbara Smith (eds.) All the Women are White, All the Blacks are Men, But Some of Us Are Brave. Old Westbury, N. Y.: The Feminist Press, 1982.

Chunn, Jay C. III et al, eds. Mental Health and People of Color: Curriculum Development and Change. Washington, D. C.: Howard University Press, 1983.

Couger, Charles D. et al. "Blaming the Client: Implicit Agenda in Practice Research", Social Work. July-August 1984, pp. 347-351. Cross Cultural Issues: Impact on Social Work Practice in Health Care: Conference Proceedings. New York: Columbia University School of Social Work, 1984.

Jackson, Jacquelyn J. Black Women: Their Problems and Power. New York: Barron's Educational Series, 1984.

Jackson, Jaquelyn J. "A Critique of Lerner's Work on Black Women and Further Thoughts", Journal of Social and Behavior Sciences, 1975, pp. 63-89.

Nobles, Jeanne. Beautiful Also Are the Souls of My Black Sisters. Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1978.

Solomon, Barbara B. "Is It Sex, Class or Race", Social Work November 1976.

* Staples, Robert. The Black Woman in America. Chicago: Nelson Hall Publishers, 1973.

Stember, Charles Herbert. Sexual Racism. New York: Elsevier, 1976.

* Watson, Wilbur H. (ed.) Black Folk Medicine: The Therapeutic Significance of Faith and Trust. New Brunswick, N. J.: Transaction, Inc., 1984.

Johnson, Audreye E. (ed.) The Black Experience: Considerations for Health and Human Services. Davis, CA.: International Dialogue Press, 1983.

Health Resources and Services Administration. Health Status of Minorities and Low Income Groups. Washington, D.C.: U. S. Government Printing Office, Public Health Services, U. S. Department of Health and Human Services Publication No. (HRSA) HRS-P-DV 85-1, 1985.

Joseph, Gloria I and Jill Lewis. Common Differences: Conflicts in Black and White Feminist Perspectives. Garden City, N. Y.: Anchor Press/Doubleday, 1981.

Bernkow, Louise. Among Women. New York: Harmony Books, 1980. Chapter 7, "The Light and the Dark: White Women are Never Lonely Black Women Always Smile".

Giddings, Paula. When and Where I Enter: The Impact of Black Women on Race and Sex in America. New York: Bantam Books, 1985.

Module II: Some Indices of Health: Bio-Psycho-Social Factors

A. Dominance, Socialization, and Control

B. Age, access to health care, income, marital status, literacy, birth history of children, occupation, family, violence, etc..

C. African-American Women and Stress

D. Some Stress Related Illnesses

Readings:

* Spurlock, Jeanne. "Black Women in the Middle Years", in Grace Baruch and Jeanne Books-Gunn (eds.) Women in Midlife. New York: Plenum Publishing Corp., 1984.

Spurlock Jeanne. "The Professional Woman as Mother: Insights From Class Differences". Vol. 40., No. 3, May/June 1985

Spurlock Jeanne. "Survival Guilt and The Afro-American of Achievement". Journal of the National Medical Association. Vol. 77, No. 1, 1985

* The New Our Bodies, Our Selves. Chapter VII, Women and the Medical System, Sections 24 and 25.

* Chestang, Leon. "The Policies and Politics of Health", in Audreye E. Johnson (ed.) The Black Experience: Considerations for Health and Human Services. Davis, CA.: International Dialogue Press, 1983.

Gross, Hervert S. et al. "The Effect of Race and Sex on the Variation of Diagnosis and Disposition in a Psychiatric Emergency Room", Journal of Nervous and Mental Disease. June 1969.

Gullatte, Alyce C. "Psychiatric Factors to Consider in Research on the Black Woman", The Journal of Afro-American Issues. Summer 1974.

Harrison, Alycia O. "Dilemma of Growing Up Black and Female", Journal of Social and Behavior Sciences. Spring 1974.

Sanders, Charles L. "Reflections on the Black Experience," in Black Agenda for Social Work in the Seventies (Atlanta University School of Social Work, 1971).

Harwood, Alan. (ed.) Ethnicity and Medical Care. Cambridge, MA: Harvard University Press, 1981.

Hickey, Tom. Health and Aging. Monterey, CA: Brooks/Cole Publishing Co., 1980.

Johnson, Audreye E. "The Black Elderly and Social Work Services", Black Caucus Journal. Spring 1983.

Morse, Donal Roy and M. Lawrence Furst. Women Under Stress. Van Nostrand Reinhold Company, 1982.

Solomon, Barbara B. "Empowering Women: A Matter of Values", in Ann Weick and Susan P. Vandiver (eds.) Women, Power, and Change. New York: NASW, 1981.

"The Burden of Black Women", in The Selected Writings of W.E.B. DuBois by Walter Nelson. New York: Mentor Books, 1970.

Tolman, Richard and Sheldon Rose. "Coping With Stress: A Multimodel Approach", Social Work. March-April 1985.

Williams, Bertha M. "Black Women: Assertiveness vs. Aggressiveness", The Journal of Afro-American Issues. Suumer 1974.

* Jackson, Jacquelyn J. Minorities and Aging. Belmont, CA.: Wadsworth Publishing Co., 1980.

* Smith, Stanley H. "The Role of Language (Communication) in Black White Relations", in Audreye E. Johnson. (ed.) The Black Experience: Social, Cultural, and Economic Considerations. Chapel Hill, N.C.: School of Social Work, University of North Carolina at Chapel Hill, 1981.

* Ladner, Joyce A. (ed.). Tomorrow's Tomorrow: The Black Woman. (Garden City, New York: Anchor Books, 1972).

Hare, Nathan and Julia. "Black Women, 1970." Transaction, November-December (1970).

Trader, Harriet P. "Survival Strategies for Oppressed Minorities," Social Work, Vol. 22, No. 1 (January 1977).

Module III: Addressing the Health Characteristics of Africanj-American Women

A. Prevention - Primary Health

B. Treatment - Secondary Health

C. Rehabilitation - Tertiary Health

Readings

* The New Our Bodies, Ourselves, Chapter V. Women Growing Older, Chapter VII, Women and the Medical System

* "Self-Help Model for Working With Black Women". in Brisbane, Frances and Maxine Womble (eds.) Treatment of Black Alcoholics. New York: The Haworth Press, in 1985.

* Gary, Lawrence E. "Utilization of Network Systems in the Black Community". in The Black Experience: Considerations for Health and Human Services.

Steiner, Joseph R. and Wynetta Devore. "Increasing Descriptive and Prescriptive Theoretical Skills to Promote Ethnic-Sensitive Practice," Journal of Education for Social Work. Spring 1983.

Schlesinger, Elfriede G. Health Care Social Work Practice: Concepts and Strategies. St. Louis: Times Mirror/Mosby, 1985.

Miller, Rosalind S. Editor. Primary Health Care: More than Medicine. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1983.

Rehr, Helen and Caroff, Phyllis, Eds. A New Model in Academic Practice Partnership: Multi-Instructor and Institutional Collaboration in Social Work. Lexington, Massachusetts: Ginn Press, 1986.

Van Horne, Winston A. and Tonnesen, Thomas V., Editors. Ethnicity and Public Policy. Milwaukee, WI: University of Wisconsin System American Ethnic Studies Coordinating Committee/Urban Corridor Consortium, 1982.

* Golub, Sharon, Editor. Health Care of the Female Adolescent. New York: The Haworth Press, 1985.

Lum, Doman. Social Work Practice & People of Color. Monterey, CA: Brooks/Cole Publishing Company, 1986.

Brisbane, Frances Larry and Womble, Maxine, Editors. Treatment of Black Alcoholics. New York: The Haworth Press, Inc., 1985.

Green, James W. Cultural Awareness in the Human Services. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1982.

Wilkinson, Doris Y. "Afro-American Women and Their Families." Marriage and Family Review 7 (Fall, 1984): 125-142.

Wilkinson, Doris Y. Minority Women: Social Cultural Issues." pp. 285-305 in A. Brodsky and R. Hare-Mustin (eds.). Women and Psychotherapy: An Assessment of Research and Practice. New York: Guilford Press, 1980.

Wilkinson, Doris Y. "Ethnic Diversity in Family Life." in M. B. Sussman and S. K. Steinmetz (eds.). Handbook of Marriage and the Family. New York: Plenum, 1986.

Osborne, Gwendolyn E. "Motherhood in the Black Community." The Crisis (December 1977).

Module IV: When and Where The Social Worker Enters

A. Service Provision

B. Service Seeking

C. Plotting the Course of Service Delivery

D. Interface of Folk and Modern Medicine

Readings:

Lide, Pauline. "The National Conference on Social Welfare and The Black Historical Perspective". Social Service Review. June 1973.

* Leigh, James W. "The Black Experience With Health Care Delivery Systems: A Focus on the Practitioner". in The Black Experience: Considerations for Health and Human Services.

* Watkins and Johnson. Removing Cultural and Ethnic Barriers To Health Care.

* Solomon, Barbara Bryant. "Innovations in Service Delivery to Black Clients", in The Black Experience: Considerations for Health and Human Services.

Sanders, Charles L. Black Professionals' Perspectives of Institutional Racism in Health and Welfare Organizations. New Jersey: R. E. Burdick, 1975.

* Jenkins, Shirley. The Ethnic Dilemma in Social Services. New York: Free Press, 1981.

* Martin, Joanne M. and Elmer P. Martin. The Helping Tradition in the Black Family and Community. Silver Spring, MD.: NASW, 1985.

Lem, Doman. Social Work Practice & People of Color: A Process-Stage Approach. Monterey CA: Brooks/Cole Publishing Co., 1986.

Burgest, David R. "Racism in Everyday Speech and Social Work Jargon." Social Work, Vol. 18, No. 4, July 1973, pp. 20-25.

* Burgest, Mwalimu David R. "Principles of Social Casework and the Third World. Iternational Social Work, Vol. XXVI, No. 3, 1983, pp. 7-23.

Burgest, David R. ed. Social Work Practice with Minorities. N. J.: Scarecrow Press, 1982.

Burgest, David R. Social Casework with People of Color. Md.: University Press of America, 1985.

Module V: Student Class Presentations

HEALTH FACTSHEET ON BLACK WOMEN:
National Black Women's Health Project

INTRODUCTION

Many of the nation's 13 million Black women suffer from chronic conditions including high blood pressure, heart disease, obesity, arteriosclerosis, kidney disease, and diabetes. In addition, the problem of teenage pregnancy is a major health and social concern. Black infant mortality rates are twice those of whites. Life stresses are often so severe that Black women experience high levels of family violence. The mere struggle to provide for one's family causes half of all Black female adults to live in psychological distress.

INCOME AND ACCESS TO HEALTH CARE

In the United States, access to health care is dependent on income level. Seventy-one percent of female headed families living below the poverty level are headed by Black women, compared to 39.5 percent for whites and 50.9 percent for Hispanics. Significant numbers of low income women depend on the Federal government to subsidize their incomes and health care services. Many such subsidized programs are now experiencing budget cuts that will decrease their ability to effectively deliver health care. The poor health of many Black Americans is due to poverty—the major cause of sickness and death.

HIGH BLOOD PRESSURE

It is estimated that one out of every four Black adults suffers from high blood pressure (hypertension). This chronic disease develops earlier in Blacks, is frequently more severe, and results in higher mortality at a younger age, more commonly from strokes. This disease can lead to stroke, heart attack, heart failure, or kidney failure. Yet once detected, high blood pressure can be controlled. For all ages of Black women, prevalence and blood pressures tend to be either equal to or higher than those of Black men.

CANCER

Breast cancer is the leading cause of death among women 35 to 55 years old. Although fewer Black women than white women suffer from breast cancer, more Black women will eventually die from it. Cervical cancer rates are increasing among Black women, while decreasing among whites. Over the past 25 years, the incidence of cancers for Black Americans has risen by 34 percent, compared to only 9 percent in whites, according to the American Cancer Society. Monthly self breast examination reduces the risk of breast cancer going undetected and becoming fatal. Periodic pap smears, the frequency to be determined by a health care provider, are recommended for all women to reduce the risk of death from cervical cancer.

DIABETES

In 1979, a diabetic was most likely to be a non-white, retired female living in a city. For Blacks aged 45 to 64, 91.3 of every 1,000 persons have been diagnosed as diabetic. This disease is closely linked with obesity, cardiovascular disease, and kidney disease. Black women show the highest susceptibility to diabetes, with a rate of 34 percent, as compared to a rate of 24.3 percent for white women, and a lightly lower rate of 21.8 percent for Black males.

INFANT MORTALITY

Although the infant mortality rates for both whites and Blacks have been declining steadily, a large differential still exists between the two racial groups. Infant death rates for Blacks at 23.1 deaths per every 1,000 births nearly doubles the rate for both whites (12.0) and Native Americans (1.37). Socioeconomic status and teenage pregnancy are significant contributors to much of this disparity. During 1981, 37 percent of all Black births were to teens, twice as high as the proportion among whites. Teenage pregnancies place these young women and their babies at high risk for health complications in later life. An estimated 20 percent of teens use contraception, while 70 percent engaging in unprotected intercourse think they cannot become pregnant.

Recent budget cuts in government programs aimed at reducing infant mortality and lowering teenage pregnancy rates will decrease prenatal care and supportive services, while increasing medical costs and death.

STRESS AND VIOLENCE

The leading cause of death in Georgia for both Black males and Black females aged 20 to 44 is homicide. Stress due to economic pressures brought on by unemployment, alcohol and drug abuse leads to an increased number of violent crimes in the Black community. The home environment is so stressful that many Black women face high levels of domestic violence. Feelings of powerlessness, low prestige, and frustration contribute to high levels of family violence. Such consistently high levels of stress from so many different areas of life also contribute to increased rates of cardiovascular diseases, mental health problems, and crime.

OTHER HEALTH ISSUES

- Regular dental health care is usually unaffordable and care is sought in crisis situations. In 1978, 82 percent of rural southern Blacks did not visit a dentist.
- Lupus attacks females in an almost nine-to-one ratio over males. It strikes one adult woman in 700, and one adult Black woman in 245.
- Black females have the highest admission rate to outpatient psychiatric services. More than half of adult Black women live in a state of psychological distress.
- When asked in 1978 to rate their overall health and "well-being" as part of a Federal National Health Interview Survey, Black females reported the lowest level of positive well being of all groups—37 percent compared to 70 percent among white males.

SUGGESTED CHANGES FOR A HEALTHIER LIFESTYLE

Many risk factors for the development of chronic diseases can be controlled by the individual. An increased awareness of these factors will enable Black women to assume more responsibility for their own health.

Suggested life style changes include:

- Proper nutrition and a balanced diet
- Weight control
- Regular exercise
- Elimination of substance abuse (alcohol, drugs, cigarettes)
- Stress management
- Self-help skills (self breast exam)
- Genetic screening and counseling
- Prenatal care
- Sex education for youth
- Evaluation of environmental and occupational health hazards
- Increased access to health care
- Preventive health information.

Reference:

Health of Minorities and Women. American Public Health Association. Washington, D.C. August 1982.

(Reprinted with permission from the National Black Women's Health Project and from SAGE.)

SELECTED RESOURCES IN MINORITY WOMEN'S HEALTH

Audiovisual Resources

The following list of films and videos was developed from a variety of resources. The journal Women and Health deserves special mention for regularly publishing helpful film reviews. The Media Network (208 W. 13th Street, New York, NY 10011, (212)620-0877) has published an excellent "Guide to Films on Reproductive Rights" which we also relied upon here.

If you are associated with a university or have access to one, we suggest you check to see if a film/video is already owned by them. You may also wish to urge your school to purchase key films you intend to use regularly.

While we have previewed many, we have not previewed all films listed and therefore recommend that you do so before using them when possible. Since rental costs change (in both directions) and availability may be limited, do contact distributors at least six weeks in advance whenever possible. Some distributors may also make video versions available upon request.

Films and videos are listed in the following categories:

- Race/Class/Culture Issues with Health Implications
- Women's Health Care Politics/Issues
- Aging
- Childbirth Education in Cultural Contexts
- Incarcerated Women
- Occupational Health
- Providers of Health Care
- Reproductive Health Issues
- Self Image/Body Image
- Violence Against Women

Race/Class/Culture Issues with Health Implications

THE WOMEN'S FILM. (1971). Focus on how women are especially victimized by class, racial and gender inequalities. Black and white, 40 min., 16 mm. Third World Newsreel, 335 W. 38th St., 5th Floor, NY, NY 10018, (212)947-9277. Rental fee $55.

OUR DEAR SISTERS. (1975). North American Indian woman discusses her life as a single parent and working mother on the reservation. 16 mm, 3/4" videocassette, 15 min. National Film Board of Canada, 1251 Avenue of the Americas, 16th Floor, NY, NY

10020-1173, (212)586-5131. Purchase only: 16mm $350, video $250.

TRIPLE JEOPARDY. Three working women--a Latina, an Afro-American and an Asian American describe the web of societal forces restricting the options of women of color and resulting in disproportionate poverty for themselves and their children. Institutionalized racism, sexism, and classism are addressed. Discussion guide. Color filmstrip, 20 min. CIBC Resource Center, 1841 Broadway, NY, NY 10023-7648, (212)757-5339. Purchase with preview $39.95.

NEVER TURN BACK: THE LIFE OF FANNIE LOU HAMER. (1982). In 1962, Fannie Lou Hamer, a 44-year old Black woman, decided to register to vote in Mississippi. Ms. Hamer became a powerful force for racial change in the South including health issues. 16 mm or video, 60 min. Rediscovery Productions, Inc., 2 Halfmile Common, Westport, CT 06880, (203)227-2268. Rental fee $120.

FEI TIEN: GODDESS IN FLIGHT. (1983). An American-born Chinese woman encounters older Chinese "bird woman" facing questions of life, death, and passing on traditions. 20 min. color, 16 mm or video. Third World Newsreel, 335 W. 38th St., 5th Floor, NY, NY 10018. Rental fee $50.

SLEEPWALKER. (1972). Features an Asian woman who deals with growing up as an American. 16 mm, black and white, 13 min. Instructional Media Library, UCLA-Powell Library, 405 Hilgard Ave., Los Angeles, CA 90024, (213)825-0755. Rental fee $25.

BLACK WOMEN'S HEALTH. The National Black Women's Health Project is developing a slideshow/video which should be available in early 1987. Focus on special health issues of black women. National Black Women's Health Project, 1237 Gordon St., S.W., Atlanta, GA 30310, (404)753-0916.

FIBROIDS. Focuses on issues of fibroids particularly affecting black women. Contact distributor for more information. National Black Women's Health Project, 1237 Gordon St., SW, Atlanta, GA 30310, (404)753-0916.

BECOMING A WOMAN. Special issues for black women. Contact distributor for more information. National Black Women's Health Project, 1237 Gordon St., SW, Atlanta, GA 30310, (404)753-0916.

Women's Health Care Politics/Issues

CHICAGO MATERNITY STORY. Focuses on health care worth fighting for-a hospital/home birth care delivery service serving black, Latina and other immigrant women. The struggle for control of the Center is shown during the period of its takeover and demise after 78 years of community service. 16mm, black and white, 60 min. New Day Films, 22 Riverview Ave., Wayne, NJ 07470, (201)633-0212.

TAKING OUR BODIES BACK: THE WOMEN'S HEALTH MOVEMENT. Explores ten critical areas of the women's health movement, showing women becoming aware of their rights in dealing with the medical industry. Dated but important. Cancer, medical research, the GYN exam, drug company attitudes, hysterectomy, care for women of color, informed consent. 16mm and 3/4 " video, 33 min, color. Cambridge Documentary Films, Inc. P.O. Box 385, Cambridge, 02139, (617)354-3677. Rental fee $45.

Aging

SILENT PIONEERS: GAY AND LESBIAN ELDERS. Some older women of color and others discuss distinctive aging issues which confront lesbians and gay men. 16mm and video, 42 min., color. Filmaker's Library Inc, 133 E. 58th St., NY, NY 10022, (212)355-6545. Rental fee $65.

Childbirth Education in Cultural Contexts

MATERNIDAD. In Spanish, a Latino extended family participates in prenatal care and husband-coached delivery in an ABC. 16 mm or video, color, 10 min. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $25.

DAR PECHO. In Spanish, focused on breastfeeding with special attention to modesty issues, maternal nutrition, and family support. 16 mm or video, color, 10 min. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $25.

TAMIKA'S BIRTH. Story of a black family's experiences during pregnancy and birth including childbirth education, nutrition, breastfeeding, etc. 16 mm or video, color, 11 min. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $25.

PARTO POR CESAREA. In Spanish, story of a couple expecting a prepared vaginal birth who "end up" with a C-section. Emphasis on maintaining family-centered birth including father at C-section and both parents with baby. 16mm and video, color, 16 min. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $25.

NUEVA VIDA. In Spanish. Both participants and some caregivers are Hispanic and Spanish-speaking. Story of a young father encouraging a friend to participate in the birth of his child by recounting his own positive experiences. Respectful of cultural traditions and extended family life. 16 mm and video, color, 14 min. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $25.

BREASTFEEDING: A SPECIAL CLOSENESS. (1978). Black, Latina and white women descrive their pleasure and the special intimacy of breastfeeding that go beyond its positive health effects. Family involvement in the effort and some difficulties women may encounter are also presented. 16 mm and video cassette, super 8, color, 23 min. Motion, Inc., 3138 Highland Pl., N.W., Washington, DC 20008, (202)363-9450. Rental fee $40.

BREASTFEEDING: A PRACTICAL GUIDE. (1982). Part I focuses on preparing for breastfeeding through early infancy. Part II focuses on postpartum and later with issues of engorgement, sore nipples and sex issues. Includes minority women as breastfeeders especially in Part II. 16 mm and video, color, 2 parts 15 min. each. Motion, Inc., 3138 Highland Pl., NW, Washington, DC 20008, (202)363-9450. Rental fee single part $40/both $50.

SAFE AND NATURAL REMEDIES FOR DISCOMFORTS OF PREGNANCY. Available in English, Spanish, Cantonese and Vietnamese. Accompanied by an English script tailored specifically to the target audience. Describes effective, practical and safe alternatives to over-the-counter drugs for the relief of pregnancy discomforts. Color slide-tape program of 110 slides also available in video. Videograph, 2833 25th St., San Francisco, CA 94110, (415)282-6001. Rental fee $40.

Incarcerated Women

INSIDE WOMEN INSIDE. A film about women prisoners including health issues. 16 mm, color, 28 min. Third World Newsreel, 335 W. 38th Street, 5th Floor, NY, NY 10018, (212)947-9277. Rental fee $40.

INVISIBLE HEALTH PROBLEMS: THE SITUATION OF WOMEN PRISONERS. Health problems of women prisoners. Video, color, 60 min. Virginia Olesen, Women, Health and Healing Program, N-631-Y, School of Nursing, University of California, San Francisco, CA 04143-0612, (415)476-2453. Rental fee $15 (cost of mailing and insuring).

LOCKED UP AND LEFT OUT: MOTHERS IN PRISON. (1984). Reveals the emotional and physical trauma to imprisoned mothers and their children, and describes a solution attempted in the State of California. There are over 100,000 women incarcerated in the United States, of whom 80% are mothers. 3/4" VHS and Beta video, color, 40 min. University Media Services, California State University at Sacramento, 6000 J Street, Sacramento, CA 95819, (916)278-6611. Rental fee $45.

Occupational Health

WORKING FOR YOUR LIFE. (1980). Occupational health issues of women in 40 different workplaces of all types. Specific work hazards along with stress and exhaustion are discussed. 16mm, color, 45 min. Film Library, P.O. Box 315, Franklin Lakes, NJ 07417. Rental fee $65.

THE GLOBAL ASSEMBLY LINE. (1984). From Tennessee to Mexico, Silicon Valley to the Philipines, the lives and health issues of women on the global manufacturing assembly line are portrayed. The comparative absence of health regulations outside of the U.S. is noted. 16 mm, color, 58 min. New Day Films, 22 Riverview Dr., Wayne, NJ 07470-3191, (201)633-0212. Rental fee $100 plus shipping.

GARMENT WORKERS IN SOUTHERN CALIFORNIA. (1975). Examines the exploitation of Mexican-American sewing machine operators in Southern California clothing factories. Documents health and labor law violations. Color, 20 min. Third World Newsreel, 335 W. 38th St., 5th Floor, NY, NY 10018, (212)947-9277. Rental fee $30.

Providers of Health Care

ALABAMA GRANNY MIDWIVES. (1984). Interviews with older Black Alabama midwives about their work and strategies for helping birthing mothers. Color documentary, 10 min., slide/tape or video only (3/4 or 1/2 "). Traditional Midwives Center International, P.O. Box 2466, East Orange, NJ 07018, (201)678-7674, evenings. Rental fee $25.

IN THE WAY OF OUR GRANDMOTHERS. (1982). Interviews with 4 midwives and decendants of midwives (of different ethnicities) about their practices and view of a midwife assisted birth. Beta or VHS, color, 26 min. Deborah Susie, 913 Willow Ave., Tallahassee, FL 32303, (904)222-3470. Rental fee $30.

DAUGHTERS OF TIME. (1981). Follows three American nurse-midwives to examine three trends in modern midwifery. The first runs an alternative birth center in a poor, Chicano area of rural Texas. All three providers are white. 16mm , color, 29 min. New Day Films, 22 Riverview Drive, Wayne NJ 07470, (201)633-0212.

MIDWIFE: WITH WOMAN. Traces the history of midwifery in America. Interviews with families, nurses and physicians about alternative childbirth experiences includes black women clients and providers. 16mm, color, 28 min. Fanlight Productions, 47 Halifax St., Boston, MA 02130, (617)524-0980. Rental fee $45.

TRADITIONAL BIRTHING: MAUDE BRYANT. (1984). Interview with a Black granny midwife from North Carolina about her life and midwifery in a rural area. Video only, color, 19 min. Distribution Department, Health Sciences Consortium, 103 Laurel Ave., Carrboro, NC 27510, (919)942-8731. Rental fee $40-80.

ALL MY BABIES. (1952). A remarkable midwifery training film made for the Georgia Departmet of Public health. Focuses on needs of and care given to poor rural Black women in the south during the 1950s. 16 mm, black and white. Available through Interlibrary loan from the National Library of Medicine (Call numbers WQ160 MP16 No. 1 and HF0929 02NLM). Rental fee $5.

Reproductive Health and Sexuality Issues

LA OPERACION. (1982). Deals with the wholesale promotion of sterilization as a means of birth and population control in Puerto Rico since 1937, including absence of informed choice. Makes connections between sterilization, colonialism and multi-national corporations. Available in Spanish or English. 16 mm and video, documentary, color, 40 min. Cinema Guild, 1697 Broadway, NY, NY 10019, (212)246-5522. Rental fee $65.

IT HAPPENS TO US. (1972). Made before the Supreme Court made abortion legal in 1973. Women of various ages, marital status and races tell about their illegal abortions, and a physician explains abortion procedures. The film gives an idea of what happens to women when abortion is illegal. 16mm film, color, 30 min. New Day Films, 22 Riverview Dr., Wayne, NJ 07470, (201)633-0212. Rental fee $40.

TRYING TIMES: CRISIS IN FERTILITY. Covers both the technical and emotional sides of infertility and includes minority women as clients. 16 mm or video, color, 33 min. Fanlight Productions, 47 Halifax St., Boston, MA 02130, (617)524-0980. Rental fee $45.

ABORTION (STORIES FROM NORTH AND SOUTH). A cross cultural survey across race, class and religious groups showing differences in practice in terms of access, danger and secrecy. Some historical background. 16 mm and video, color, 55 min. The Cinema Guild, 1697 Broadway, NY, NY 10019, (212)246-5522. Rental fee $100.

SICKLE CELL ANEMIA. Scientific information followed by an interview with a family in which parents were inadvertent carriers and children are variously affected. 16 mm or video, color, 22 min. Filmmaker's Library, Inc., 133 E. 58th St., NY, NY 10022, (212)355-6545. Rental fee $50.

THE ULTIMATE TEST ANIMAL. (1985). Documentary examining the injectible means of birth control Depo Provera used extensively in the Third World and promoter's fight to legalize its use as a contraceptive in the U.S. Shows women's experiences and activism to prevent its approval and international use. Raises important issues regarding both racism and sexism in health care. Video only, color, 40 min. Cinema Guild, 1697 Broadway, NY, NY 10019, (212)246-5522. Rental fee $55.

SUDDEN CHANGES: POST HYSTERECTOMY SYNDROME. (1986). Documentary focused on personal interviews with women and physicians about problems which some women confront after hysterectomy including lack of desire for sex, vaginal dryness, discomfort. Shows alternatives to hysterectomy in some situations. Video only, color, 29 min. Cinema Guild, 1697 Broadway, NY, NY 10019, (212)246-5522. Rental fee $50.

PERSONAL DECISIONS. (1986). Advocates safe abortions for all women. Interviews with women of different races about their experiences and need for abortion under varied life conditions. 16 mm and video, color, 30 min. Cinema Guild, 1697 Broadway, NY, NY 10019, (212)246-5522. Rental fee $50.

TAKING CHARGE. (1985). Teenage perspectives on birth control with an Hispanic physician and several teenagers discussing issues. 16 mm or video, color, 22 min. Fanlight Productions, 47 Halifax, Boston, MA 02130, (617)524-0980. Rental fee $50.

CHOOSING CHILDREN: A FILM ABOUT LESBIANS BECOMING PARENTS. (1985). An intimate look at issues faced by women of different races who become parents after coming out as lesbians: new options, donor insemination, non-biological mothers, biological fathers, adoption, male role models and homophobia. Study guide available. 16 mm and 3/4" video, color, 45 min. Cambridge Documentary Films, Inc., P.O. Box 385, Cambridge, MA 02139. (617)354-3677. Rental fee $65.

BABIES MAKING BABIES. (1978). Story of a 15 year old black girl/woman's unintended pregnancy. Birth control issues, saying "no," and need to discuss sexuality are covered. 16 mm and 3/4" video, color, 21 min. The Black Filmaker Foundation, 80 8th Ave., Suite 1704, NY, NY 10011, (212)924-1198. Rental fee $75.

IN THE BEST INTERESTS OF THE CHILDREN. (1977). Interviews with lesbian mothers and their children. Black and white, middle class, professional and welfare mothers all discuss their struggles for child custody. The children discuss their mothers as lesbians and their own attitudes about sexuality. 16 mm and video, color, 53 min. Women Make Movies, 225 Lafayette St., Suite 212, NY, NY 10012, (212)925-0606. Rental fee $100.

Self Image/Body Image

KILLING US SOFTLY--ADVERTISING'S IMAGE OF WOMEN. (1979). This film analyzes the $40 billion advertising industry aimed at influencing women's attitudes about their gender, bodies and self-esteem. Examples of sexist advertising designed to exploit, manipulate, and degrade women of different races in different ways. Color, 30 min. Cambridge Documentary Films, P.O. Box 385, Cambridge, MA 02139, (617)354-3677. Rental fee $46.

Violence Against Women

TO LOVE, HONOR AND OBEY. Documentary focusing on the realities faced by women from varied racial and class backgrounds who have survived experiences of physical abuse by men. Social, cultural and psychological issues. 16 mm, color, 60 min, purchase price $80; Beta/VCR purchase price $85. Third World Newsreel, 335 W. 38th St., 5th Floor, NY, NY 10018, (212)947-9277.

SUZANNE, SUZANNE. Three generations of black women recount the legacy and complexities of domestic violence, drug abuse, and alcohol addiction in their households. 16 mm, black and white, 30 min. Third World Newsreel, 335 W. 38th St., 5th Floor, NY, NY 10018, (212)947-9277. Rental fee $50.

RAPE CULTURE. (1983). Interviews women and men of color and whites about attitudes about rape. Includes rape of women and rape of men in prison. 16 mm and 3/4" video, color, 35 min. Cambridge Documentary Films, P.O. Box 385, Cambridge, MA 02139, (617)354-3677. Rental fee $46 plus shipping.

WHY WOMEN STAY. Documentary examines the complex reasons why women remain in violent homes and exposes the social structures that victimize women and contribute to their abuse. 3/4" video, black and white, 30 min. Women Make Movies, Inc., 225 Lafayette St., Suite 212, New York, NY 10012, (212)925-0606. Rental fee $40.

WAKING UP TO RAPE. A documentary focused on three women's (2 are women of color) experiences including social, psychological and other consequences. Focus on empowering women to cope with rape. 16 mm and video (3/4" and VHS), color, 30 min. Women Make Movies, Inc., 225 Lafayette St., Suite 212, NY, NY 10012, (212)925-0606. Rental fee $60.

GIVE IT ALL YOU'VE GOT. Focus on five women of different races who have taken a self-defense class and used these techniques to successfully deter an assault. 16 mm or video, color, 16 min. UCSF Rape Prevention Educational Program, Women's Resource Center, 1308 Third Ave., San Francisco, CA 94143, (415)476-5222. Rental fee $20.

RESEARCH CLEARINGHOUSE ON WOMEN OF COLOR AND SOUTHERN WOMEN
CENTER FOR RESEARCH ON WOMEN

The Center for Research on Women at Memphis State University was founded in 1982 with an initial grant from the Ford Foundation. The major objectives of the Center are to conduct, promote, and advance research on women of color in the United States and Southern women. To that end we have worked closely with scholars in these developing fields as well as with faculty and students who need information on these groups of women.

From the beginning, we at the Center have been aware of the difficulties in locating social science and historical materials on these groups. The interdisciplinary nature of women's studies complicates the research process for many students, teachers and scholars. The research process is often further complicated because materials on women of color and Southern women are frequently located in journals and publications which are not indexed in many of the major on-line data bases. To address these problems and to aid in locating and disseminating research on women of color and Southern women, the Center for Research on Women developed the Research Clearinghouse.

The Research Clearinghouse on Women of Color and Southern Women is designed to provide scholars, educators, students, policy makers, and the general public with up-to-date bibliographic and human resource information on research which focuses on these two groups of women. This project was initially funded in 1984 by the U.S. Department of Education's Fund for the Improvement of Postsecondary Education (FIPSE).

The Clearinghouse is a computer-based information retrieval system. It includes three major files: (1) a "human resource file" of individual researchers containing such information as institutional affiliation, areas of research interests, published and unpublished work, etc.; (2) an indexed file of full bibliographic citations for works focusing on these groups of women; and (3) a thesaurus type vocabulary of keyword descriptors to enhance the utility of the system.

The Clearinghouse covers social science research produced since 1975 in the fields of sociology, anthropology, economics, political science, history, women's studies, ethnic studies, social psychology and education. The Center collects information on research from a variety of sources including individual researchers, organizations (e.g., ethnic and women's studies centers), bibliographies, and so forth. The data base currently contains 2,500+ up-to-date references to books, journal articles, chapters in books, unpublished works (including doctoral dissertations) and non-print materials.

Until now, there has been no centralized data base of information on women of color and Southern women. Although placement on these groups has been incorporated into some existing data bases, they tend to be limited in any of the following ways: they are restricted to information in certain disciplines; lack information about unpublished or in-progress work; are organized so that information is not retrievable by race, class, gender and region; or contain limited references about research, and no information about researchers working in these areas.

The Research Clearinghouse defines women of color to include Native American Indians; Afro-Americans (West Indian Americans, African immigrants to the United States, etc.); Latinas (Puerto Ricans, Mexicans, Cubans, and other women of Latin origin); Asian Americans (Chinese, Japanese, Korean, Thai, and other women of Asian origin); and Pacific Islanders (Filipinas, Hawaiians, Tongans, etc.). Southern women include women from Washington, DC and from the following states: Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

In addition to identifying citations from recently published books, leading journals, and many publications not routinely covered by other bibliographic services, a National Advisory Board of over twenty social scientists and historians monitor the new research in their fields and recommend entries for the data base. Each reference in the data base is indexed by up to eight keyword descriptors according to terms employed by the National Council for Research on Women's The Women's Index, a women's studies thesaurus. This thesaurus was developed as a collaborative project of women's research centers across the nation including our Center.

In conjunction with the Research Clearinghouse, the Curriculum Integration Project focuses on disseminating information to Memphis and Mid South area college faculty as well as other faculty across the nation. This is accomplished with the monthly "Seminar on Women in the Curriculum", which is held throughout the academic year. At the end of May, the project hosts the "Annual Workshop on Women in the Curriculum", a 3-day event which demonstrates the Research Clearinghouse data base; provides teachers, faculty and administrators with the opportunity to revise course(s) either being taught or created; and introduces innovative resources for classroom use (e.g., films, visual aids, etc.). The Clearinghouse has recently published the keynote addresses from the 1985 and 1986 Workshops, which are now available for purchase.

For information on Clearinghouse resources, requesting a search, becoming a part of the human resource file, or curriculum workshops, call or write the Research Clearinghouse, c/o Center for Research on Women, at the address above.

CENTER FOR RESEARCH ON WOMEN
RESEARCH CLEARINGHOUSE

MEMPHIS STATE UNIVERSITY
SEARCH REQUEST FORM

NAME ______________________________

INSTITUTION ______________________________

ADDRESS ______________________________

CITY ______________________ STATE ______ ZIP __________

HOME TELEPHONE (____) __________ WORK TELEPHONE (____) __________

DO YOU WANT THE SEARCH ☐ MAILED TO YOU, OR ☐ WILL YOU PICK IT UP? IF IT IS TO BE PICKED UP, WHO WILL PICK IT UP AND WHEN?

____

DESCRIPTION OF YOUR SEARCH TOPIC: BE AS SPECIFIC AS POSSIBLE.

____

____

____

____

____

FILES TO BE SEARCHED: CHECK FOR ALL FILES ☐, OR SPECIFY BELOW:

☐ HUMAN RESOURCE FILE
☐ CHAPTERS IN A BOOK
☐ UNPUBLISHED WORKS

BOOKS ☐
PUBLISHED ARTICLES ☐
NONPRINT MATERIALS ☐

HUMAN RESOURCE FILE ONLY: CHECK REGIONS FOR RESEARCHER'S LOCATION. REGIONS CORRESPOND TO THOSE OUTLINED BY U.S. CENSUS BUREAU.

☐ ALL REGIONS
☐ MID ATLANTIC
☐ EAST NORTH CENTRAL
☐ WEST NORTH CENTRAL
☐ MOUNTAIN

NEW ENGLAND ☐
SOUTH ATLANTIC ☐
EAST SOUTH CENTRAL ☐
WEST SOUTH CENTRAL ☐
PACIFIC ☐

PUBLICATION DATES: COVERAGE PROVIDED FROM 1975 TO THE PRESENT; SOME FILES MIGHT CONTAIN EARLIER YEARS.

☐ SEARCH ALL YEARS, OR SPECIFY YEARS ____________________ ☐

AUTHOR SEARCH: LIST AUTHORS COMPLETE NAMES (ALL FILES SEARCHED).

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

REQUESTORS: COMPLETE FRONT SIDE OF SEARCH REQUEST FORM ONLY.

REQUESTORS: COMPLETE FRONT SIDE OF SEARCH REQUEST FORM ONLY.

FOR OFFICE USE ONLY

RECEIVED ________ SEARCHED ________ MAILED ________

RESULTS ________ COST $________ SEARCHER ________

NOTES: ________

THIS SPACE PROVIDED AS A SEARCHERS WORKSHEET

REQUESTORS: COMPLETE FRONT SIDE OF SEARCH REQUEST FORM ONLY.

CLEARINGHOUSE DATA FORM

(Please Print or Type)

Name: ______________________________

Address (H): ______________________________
Street City State Zip

Telephone: (   ) ____________ Position: ____________

Address (W): ______________________________
Street City State Zip

Telephone: (   ) ____________ Race/Ethnicity (Optional) ____________

Please check the box if you *do not* wish to have your phone numbers or home address made available to users of the Clearinghouse. ☐

The Research Clearinghouse is a computer based resource which contains complete citations to published and unpublished works; descriptions of ongoing research projects and where to contact researchers. It is limited to social science research (including history) on women of color and Southern women that has been published in the last 10 years or is in progress.

Please list your areas of interest which are relevant to our Clearinghouse by using keywords and phrases.

1. ____________ 4. ____________

2. ____________ 5. ____________

3. ____________ 6. ____________

In the space below, please provide a brief descriptive paragraph about your ongoing research projects and other research interests. Wherever applicable, use the keywords you supplied above.

Ongoing Research: (Here describe your research in progress and please provide a tentative title for each project.)

Other Research Interests:

124 Please supply us with a summary vita or a list of all relevant published or unpublished works which we may add to our Clearinghouse data base. (Please feel free to send us copies of your works for Center use only.)

Return to: Center for Research on Women
Clement Hall - Room 339
Memphis State University
Memphis, Tennessee 38152

An Equal Opportunity/Affirmative Action University

V. RESOURCES FOR TEACHING WOMEN, HEALTH AND HEALING

B. RESOURCES ON WOMEN, HEALTH AND HEALING

SECTION INTRODUCTION

In this section we have attempted to provide both basic resources and resources in areas which have generally been underdeveloped in women's health studies. The listings of key organizational resources and the major journals publishing work on women, health and healing are basic resources with current addresses and information.

The BIBLIOGRAPHY AND RESOURCES ON RURAL WOMEN'S HEALTH IN THE U.S. should provide core readings and audio-visual materials on an underdeveloped area for curricular integration at all post-secondary levels. While materials in this area remain scant, further work is currently being done.

Another exciting new area of scholarship salient to women's health studies has been called women in/and science or gender and science. Our bibliography of this growing field includes basic works published to date and is focused on edited volumes with articles related to women's health issues. Most if not all of these works ask new epistemological questions about the social construction of knowledge in the sciences, especially the life sciences, which are important to integrate into women's health studies.

Given our goal of stimulating curricular integration, this volume would not have been complete without resources to aid this cause. Those interested can use our short bibliography to locate further references.

We have provided a subscription form for NURSING SCAN--WOMEN'S HEALTH published by the Women's Health Exchange at the School of Nursing, University of Illinois at Chicago. This quarterly annotated bibliography monitors the major nursing journals, feminist scholarly journals and medical journals and lists all articles published on women's health topics. The range of journals examined includes HEALTH CARE FOR WOMEN INTERNATIONAL, AMERICAN JOURNAL OF PUBLIC HEALTH, SIGNS, and the NEW ENGLAND JOURNAL OF MEDICINE.

Last we include order forms for our other curricular development materials in women's health studies. See the Introduction to this volume for a full description.

KEY ORGANIZATIONS AND RESOURCES IN WOMEN, HEALTH AND HEALING

The following list is focused on organizations, and resources which address women's health issues from more scholarly than activist perspectives. The Boston Women's Health Book Collective's THE NEW OUR BODIES, OURSELVES (Simon and Schuster, 1984) offers excellent listings of activist groups focused on a wide range of issues. Many of the following organizations have newsletters or other publications which would be of curricular assistance. For faculty attempting to develop resources in women's health, we strongly recommend that you send a form letter to each of these groups requesting a list of current publications. Such materials can be invaluable for both student research projects and faculty curriculum development.

Alan Guttmacher Institute
515 Madison Avenue
New York, NY 10022
[publications on family planning topics]

Boston Women's Health Collective
P.O. Box 192
Somerville, MA 02144

Disabled Women's International
c/o Janne Sander, Knudsen,
Gadekaervej 28, 2.th, 2500
Valby, Copenhagen
Denmark

International Childbirth Education Association
P.O. Box 20048
Minneapolis, MN 55420

Health Research Group
2000 P St., N.W. [#2]
Washington, D.C. 20036

International Confederation of Midwives
57 Lower Belgrave St.
London, England

Mari Spehar Health Education Project
P.O. Box 545
Fayetteville, AR 72701

National Abortion Rights Action League
825 15th St., N.W.
Washington, D.C. 20025

National Center for Education in Maternal and Child Health
3520 Prospect St., N.W.
Washington, D.C. 20057
(202) 625-8400

National Health Law Program
2639 LaCienega Blvd.
Los Angeles, CA 90034

National Midwives Association
Women's Legislative Service
324 C St., S.E.
Washington, D.C. 20003

National Organization of Adolescent Pregnancy and Parenting
820 Davis St.
Evanston, IL 60201

National Organization for Women
425 13th St., N.W.
Washington, D.C. 20004

National Perinatal Association
1311A Dolly Madison Blvd.
McLean, VA 22101

National Women's Health Network
224 7th St., S.E.
Washington, D.C. 20003
[offers a wide variety of publications in women's health]

Project on the Status and Education of Women
Association of American Colleges
1818 R St., N.W.
Washington, D.C. 20009
[offers listings of minority women's organizations and programs and of centers of research on women as well as special focus materials, e.g. sexual harassment on campus]

Religious Coalition for Abortion Rights
100 Maryland Avenue, N.E.
Washington, D.C. 20002

Sex Information and Education Council of the U.S. (SIECUS)
84 Fifth Ave. Suite 403
New York, NY 10011

Society for Menstrual Cycle Research
c/o Dr. Barbara Sommer
Department of Psychology
University of California, Davis
Davis, CA 95616

Women and Health Roundtable
Federation of Organizations for Professional Women
2000 P St., N.W. Suite 403
Washington, D.C. 20037

Women's Equity Action League
Educational and Legal Defense Fund
733 15th St., N.W. Suite 200
Washington, D.C. 20006

Women's Legislative Service
324 C St., S.E.
Washington, D.C. 20003

Women's Occupational Health Resource Center
Columbia University
School of Public Health
60 Haven Ave. [B1[
New York, NY 10032

JOURNALS IN WOMEN, HEALTH AND HEALING

All of the following journals publish materials in women, health and healing and several specialize in women's health topics. Faculty should request that those most pertinent be acquired by your university library.

FEMINIST ISSUES
Transaction, Inc., Dept. 8200
Rutgers--The State University
New Brunswick, NJ 08903

FEMINIST STUDIES
C/O Women's Studies Program
University of Maryland
College Park, MD 20742

FEMINIST TEACHER
Ballantine 442
Indiana University
Bloomington, IN 47405

FRONTIERS
Women's Studies Program
University of Colorado
Boulder, CO 80309

GENDER AND SOCIETY
Sage Publications
275 South Beverly Drive
Beverly Hills, CA 90212

HEALTH CARE FOR WOMEN INTERNATIONAL
Hemisphere Publishing Corp.
1010 Vermont Ave., N.W.
Washington, D.C. 20005

RADICAL TEACHER
P.O. Box 102, Kendall Square Post Office
Cambridge, MA 02142

SAGE: A SCHOLARLY JOURNAL ON BLACK WOMEN
P.O. Box 42741
Atlanta, GA 30311-0741

SCIENCE FOR THE PEOPLE
897 Main St.
Cambridge, MA 02139

SIGNS: A JOURNAL OF WOMEN IN CULTURE AND SOCIETY
University of Chicago Press
P.O. Box 37005
Chicago, IL 60637

WOMEN AND HEALTH
Haworth Press
28 E. 22nd St.
New York, NY 10010

WOMEN AND THERAPY
Haworth Press
28 E. 22nd St.
New York, NY 10010

WOMEN'S REVIEW OF BOOKS
Dept. 1/Women's Review
Wellesley College Center for Research on Women
Wellesley, MA 02181-8255

WOMEN'S STUDIES: AN INTERDISCIPLINARY JOURNAL
Gordon and Breach Pubs.
50 West 23rd St.
New York, NY 10010

WOMEN'S STUDIES INTERNATIONAL FORUM
Pregamon Press
Maxwell House, Fairview Park
Elmsford, NY 10523

WOMEN'S STUDIES QUARTERLY
THE FEMINIST PRESS
City University of New York
311 E. 94th St.
New York, NY 10028

BIBLIOGRAPHY AND RESOURCES ON RURAL WOMEN'S HEALTH IN THE U.S.

Compiled by Patricia Hanson, Dorothy Battenfeld & Adele Clarke

An underdeveloped area in women's health studies has long been the health issues of rural women. This bibliography and resources listing should enable faculty to include rural perspectives on women's health in the curriculum, either as autonomous units or within specific health issues.

Ahearn, M.C. Health Care in Rural America. U.S. Department of Agriculture, Bulletin # 428, Washington, D.C. 20250, 1979.

Baker, Deborah. The Class Factor: Mountain Women Speak Out On Women's Health. In Claudia Dreifus (Ed.) Seizing Our Bodies: The Politics of Women's Health. New York: Vintage/ Random House, 1977:223-234.

Battenfeld, D., E. Clyft, and R. Graubarth (Eds.) Patterns for Change: Rural Women Organizing for Health. National Women's Health Network, Washington, D.C. 1981.

Barton, S., D.W. Coombs, and R. Moore. Urban-Rural Suicide Differentials in Alabama in 1967-1975. Alabama Journal of Medical Sciences 14(1977):306-315.

Berkowitz, A. and D. Hedlund. Psychological Stress and Role Congruence in Farm Families. Cornell Journal of Social Relations 14(1979)47-58.

Berry, Wendell. The Unsettling of America. Jackson, CA: Sierra Pub. Co., 1977.

Bescher-Donnely, L. and L. Smith. The Changing Roles and Status of Rural Women. In R. Coward and W. Smith (Eds.) The Family in Rural Society. Boulder: Westview Press, 1981.

Bigbee, J.L. Rural-Urban Differences in Hardiness, Stress and Illness Among Women. Unpublished dissertation: University of Texas at Austin, 1985.

Bigbee, J.L. The Changing Role of Rural Women: Nursing and Health Implications. Health Care for Women International 5(1984):307-322.

Special Issue: Rural Health Needs, Programs and Services. Biosciences Communications 4(1)1978.

Davenport, J. and J. The Rural Rape Crisis Center: A Model. Human Services In the Rural Environment 1(1), 1979.

D'Ercole, A.J. r. Arthur, J. Caine and B. Barrentine. Insecticide Exposure of Mothers and Newborns in a Rural Agricultural Area. Pediatrics 57(6)1976:869-873.

Easterlin, R.A. Factors in the Decline of Farm Family Fertility in the U.S.: Some Preliminary Research Results. Journal of American History 63(1976):600-614.

Flax, J.W. et al. Mental Health and Rural America: An Overview. Community Mental Health Review 3(1978):1-15.

Flora, C. and S. Johnson. Discarding the Distaff: New Roles for Rural Women. In T. Ford (Ed.) Rural U.S.A.: Persistence and Change. Ames: Iowa State University Press, 1978.

Fink, Deborah. Rural Women and Family in Iowa. International Journal of Women's Studies Jan./Feb., 1984:57-69.

Haney, W.G. Women. In D.A. Dillman and D.J. Hobbs (Eds.) Rural Society in the U.S.: Issues for the 1980s. Boulder: Westview Press, 1982:124-135.

Hein, H. and N. Ferguson. The Cost of Maternity Care in Rural Hospitals. Journal of the American Medical Association 240(19)1978:2051-2052.

Hill, C.E. Black Healing Practices in the Rural South. Journal of Popular Culture, 1972.

Hoffmaster, J.E. Rural Maternity Services: Community Health Nurse Providers. Journal of Community Health Nursing 3(1)1986:25-33.

Jensen, J. Native American Women and Agriculture: A Case Study. Sex Roles 3(1977):423-441.

Kahn, Kathy. Hillbilly Women. New York: Avon, 1972.

Lichty, S. and A. Zuvekas. Rural Health: Policies, Progress and Challenges. Urban Health 9(7)1980.

Miller, M.K. Health and Medical Care. In D.A. Dillman and D.J. Hobbs (Eds.) Rural Society in the U.S.: Issues for the 1980s. Boulder: Westview Press, 1982:216-223.

Mulligan, J.E. Pregnant Americans, 1918-1947: Some Public Policy Notes on Rural and Military Wives. Women and Health 5(4) 1980:23-38.

Navarro, Vincente. Health and Medicine in the Rural U.S.: Its Political and Economic Determinants. In his Medicine Under Capitalism. New York: Prodist, 1976:67-81.

Padfield, M. Comparative Effects of Two Counseling Approaches on Intensity of Depression Among Rural Women of Low Socioeconomic Status. Journal of Counseling Psychology 23(1976):209-214.

Seims, S. Abortion Availability in the U.S. Family Planning Perspectives 12(2)1980.

Shako, Arlene. Rural Life: Romance versus Reality. Catholic Rural Life, Sept., 1984.

Shako, Arlene. Farm and Rural Stress. Psychiatric Outpatient. 1982.

Slesinger, D.P. Racial Residential Differences in Preventive Medical Care for Infants in Low Income Populations. Rural Sociology 45(1)1980:69-70.

Smedley, Agnes. Daughter of the Earth. New York: The Feminist Press, 1973.

Spruill, Julia Cherry. Women's Life and Work in the Southern Colonies. New York: W.W. Norton, 1972 (reprint of 1938).

Walters-Bugbee, C. "And None of Them Left-Handed": Mid-wife from Plains. Southern Exposure 5(1):4.

W.E.E.A. Publishing Center. A Common World: Courses in Women's Studies for Rural and Urban Communities. 1982. Available from W.E.E.A. Publishing Center, Education Development Center, 55 Chapel St., Newton, MA 02160. [800-225-3088].

Zeidenstein, S. Learning About Rural Women. Studies in Family Planning 10(11-12)1979.

AUDIOVISUAL MATERIALS ON RURAL WOMEN'S LIVES AND HEALTH

ALL MY BABIES (1952)
A remarkable midwifery training film made for the Georgia Department of Public Health. Focus on needs of and care given to poor Black pregnant women in rural areas. 16mm, black and white. Available through interlibrary loan from the National Library of Medicine (Call numbers WQ160 MP16 No. 1 and HF0929 02NLM) 8600 Rockville Pike, Bethesda, MD 20894. 301-496-5511. Rental fee $5.

COAL MINING WOMEN (1982)
Portrays the work and occupation health issues confronted by women employed as coal miners largely in Appalachia. 40 minutes, rental cost is $70 plus $5 shipping. Available from Appalshop Films/Videos. Box 743, Whitesburg, KY 41858. 800-545-SHOP.

FIVE CONVERSATIONS ABOUT VIOLENCE (Headwaters Television)
Focus on family and other violence in rural situations. 30 minutes, available for sale only at $150. From Appalshop Films/Video. Box 743, Whitesburg, KY 41858. 800-545-SHOP.

FRONTIER NURSING SERVICE (1984)
Examines an earlier era of this pioneer service in nurse midwifery in Kentucky. Available from Appalshop Films, Box 743, Whitesberg, Kentucky 41858. 800-545-SHOP/606-633-0108.

LA CHICANA
Offers an historical overview of Chicana women's lives and work in America to the present, including extensive coverage of rural life. 22 minutes. Available from Ruiz Productions, P.O. Box 27788, Los Angeles, CA 90027.

STRANGERS AND KIN: A HISTORY OF THE HILLBILLY IMAGE (1984)
An in-depth look at the myths and realities of hillbilly life historically and today. 58 minutes. Available from Appalshop Films, Box 743, Whitesburg, Kentucky 41858. 800-545-SHOP.

A number of films/videos on rural themes are widely available on VHS and BETA for rental at video franchises:

- COUNTRY
- HARLAN COUNTY, U.S.A.
- RESURRECTION
- COAL MINER'S DAUGHTER
- PLACES IN THE HEART

SEE ALSO Audiovisual Resources on Minority Women's Health, especially the Section on providers of health care. Several of these films deal with rural midwives and other providers of varied ethnic backgrounds.

ORGANIZATIONS CONCERNED WITH RURAL WOMEN'S HEALTH

NATIONAL HEALTH LAW PROGRAM
2639 South La Cienega Blvd.
Lost Angeles, CA 90034

NATIONAL RURAL HEALTH ASSOCIATION
publishes Rural Health Care Newsletter (6 issues per year)
2220 Holmes St.
Kansas City, Missouri 64108
also publishes Journal of Rural Health (3 issues per year)
c/o The Center for Rural Studies
448 Waterman Hall
University of Vermont
Burlington, VT 05405-0160

NATIONAL WOMEN'S HEALTH NETWORK
224 Seventh St. S.E.
Washington, D.C. 20003
Committee on Rural Women's Health
C/O Maureen Flannery
Rt. 75, Box 11870
Hindman, Kentucky 41822

RURAL AMERICAN WOMEN
1522 K St. Suite 700
Washington, D.C. 20005
202-785-0634

WOMEN OF ALL RED NATIONS
Box 2508
Radpid City, South Dakota 57709

BASIC BIBLIOGRAPHY ON WOMEN, SCIENCE AND HEALTH ISSUES

Compiled by Adele Clarke

In recent years a new field of scholarship has emerged, feminist science studies, which has much to offer us in women's health. Many of the contributors are biologically and/or medically trained and all bring a host of important questions to bear upon the nature of biomedical theory, the organization of research, research agendas and medical practice. The questions they raise are fundamental to deepening our understanding of basic problems in women's health. The epistemologies of health, illness, medicine and biology are challenged in ways which deserve our serious attention. This core bibliography can serve both as the basis for library acquisitions and the development of new courses, lectures and other types of curricular development which can direct women's health studies in innovative directions.

Arditti, Rita, Renate Duelli Klein and Shelley Minden (Eds.) Test-Tube Women: What Future for Motherhood? Boston: Pandora/ Routledge and Kegan Paul, 1984.

Bleier, Ruth. Science and Gender: A Critique of Biology and Its Theories on Women. New York: Pergamon Press, 1984.

Bleier, Ruth (Ed.) Feminist Approaches to Science. New York: Pergamon Press, 1986.

Bordo, Susan. The Cartesian Maculinization of Thought. Signs 11(3)1986:439-456.

Brighton Women and Science Group (Lynda Birke, Wendy Faulkner, Sandy Best, Dierdre Janson-Smith and Kathy Overfield). Alice Through the Microscope: The Power of Science Over Women's Lives. London: Virago Press, 1980.

Clarke, Adele. Emergence of the Reproductive Research Enterprise: A Sociology of Biological, Medical and Agricultural Science in the U.S., c1910-1940. Unpublished dissertation, U.C., San Francisco, 1985. University Microfilms # DAO 58785.

Fee, Elizabeth. Women's Nature and Scientific Objectivity. In Marian Lowe and Ruth Hubbard (Eds.) Woman's Nature: Rationalizations of Inequality. New York: Pergamon Press, 1983.

Fee, Elizabeth (Ed.) Women and Health: The Politics of Sex in Medicine. Farmingdale, NY: Baywood Press, 1983.

Goodman, Madeleine J. and Lenn Evan Goodman. Is There a Feminist Biology? International Journal of Women's Studies 4(4)1981:393-413.

Gornick, Vivian. Women in Science: Portraits from a World in Transition. NY: Simon and Schuster, 1984.

Haraway, Donna. In the Begining Was the Word: The Genesis of Biological Theory. Signs 6(3)1981:469-81.

Haraway, Donna. Animal Sociology and a Natural Economy of the Body Politic, Part I: A Political Physiology of Dominance, and Part II: The Past is the Contested Zone: Human Nature and Theories of Production and Reproduction in Primate Behavior Studies. Signs 4(1)1978:21-60.

Harding, Sandra. The Science Question in Feminism. Ithaca: Cornell University Press, 1986.

Harding, Sandra and Merrill B. Hintikka (Eds.) Discovering Reality: Feminist Perspectives on Epistemology, Metaphysics, Methodology and the Philosophy of Science. Boston: Kluwer, 1983.

Hrdy, Sarah Blaffer. The Woman that Never Evolved. Cambridge: Harvard University Press, 1981.

Hubbard, Ruth, Mary Sue Henifin and Barbara Freid (Eds.) Biological Woman: The Convenient Myth. Cambridge, MA: Schenkman, 1982. [Contains a major bibliography.]

Hubbard, Ruth and Marian Lowe (Eds.) Genes and Gender II: Pitfalls in Research on Sex and Gender. New York: Gordian Press, 1979.

HYPATIA: A Journal of Feminist Philosophy is planning a special issue on women and science.

Keller, Evelyn Fox. Gender and Science. Psychoanalysis and Contemporary Science 1(1978):409-33.

Keller, Evelyn Fox. A Feeling for the Organism: The Life and Work of Barbara McClintock. San Francisco: W.H. Freeman, 1983.

Keller, Evelyn Fox. Feminism and Science. Signs 7(3)1982:589-602.

Keller, Evelyn Fox. Reflections on Gender and Science. New Haven: Yale University Press, 1985.

Lowe, Marian and Ruth Hubbard (Eds.) Woman's Nature: Rationalizations of Inequality. New York: Pergamon Press, 1983.

Longino, Helen and Ruth Doell. Body, Bias and Behavior: A Comparative Analysis of Reasoning in Two Areas of Biological Science. Signs 9(2)1983:206-227.

McGaw, Judith. Women and the History of American Technology: A Review. Signs 7(4)1982:798-828.

Merchant, Carolyn. Isis' Consciousness Raised. Isis 73(1982)398-409.

Merchant, Carolyn. The Death of Nature: Women, Ecology and the Scientific Revolution. San Franciaco: Harper and Row, 1980.

Newman, Louise Michelle (Ed.) Men's Ideas/Women's Realities: Popular Science, 1870-1915. New York: Pergamon Press,

Rose, Hilary. Hand, Brain and Heart: A Feminist Epistemology for the Natural Sciences. Signs 9(1)1983:73-90.

Rosser, Sue. Teaching Science and Health from a Feminist Perspective: A Practical Guide. New York: Pergamon, 1986.

Rossiter, Margaret W. Women Scientists in America: Struggles and Strategies to 1940. Baltimore: Johns Hopkins University Press, 1982.

Rothschild, Joan (Ed.) Machina Ex Dea: Feminist Perspectives on Technology. New York: Pergamon, 1983.

Rothschild, Joan. Teaching Technology from a Feminist Perspective: A Practical Guide. New York: Pergamon, 1986.

Sapiro, Virginia (Ed.) Women, Biology and Public Policy. Beverly Hills: Sage, 1985.

Special Issue: Women, Science and Society. Signs 4(1)1978.

Tobach, Ethel and Betty Rosoff (Eds.) Genes and Gender III: Genetic Determinism and Children. NY: Gordian Press, 1980.

Zimmerman, Jan. The Technological Woman: Interfacing with Tomorrow. New York: Praeger, 1983.

SHORT BIBLIOGRAPHY ON CURRICULAR INTEGRATION

Compiled by Adele Clarke and Virginia Olesen

This short bibliography includes a variety of topics in curricular integration. It is not limited to health issues or integrating minority perspectives because effective strategies for curricular development in women, health and healing may be gleaned from diverse sources. Women's studies sources are particularly helpful, and the WOMEN'S STUDIES QUARTERLY regularly publishes pedagogical materials which are directly relevant to teaching women's health.

Banfield, Beryl. The Total Approach: Integrating the History of African Americans and Women into the Curriculum. $2.25 from the Race Desegregation Assistance Center, Metropolitan Center for Educational Research and Development, New York University, New York, NY 10003.

Banner, Lois. The Princeton Project on Women in the College Curriculum. 308 West College, Princeton University, Princeton, NJ 08540.

Bogart, Karen. Toward Equity: An Acation Manual for Women in Academe. Washington, D.C.: Association of American Colleges, 1984.

Boxer, Marilyn J. For and About Women: The Theory and Practice of Women's Studies in the United States. SIGNS 7(3)1982:661-695.

Bunch, C. and S. Pollack. Learning Our Way: Essays in Feminist Education. Trumansburg, NY: The Crossing Press, 1983. Feminist

Chapman, Anne. Feminist Resources for Schools and Colleges: A Guide to Curricular Materials. Third Edition. Old Westbury: The Feminist Press, 1985.

Chew, Martha. A Survival Course for Women Entering a Male-Dominated Profession: Women's Studies at the Massachusetts College of Pharmacy and Allied Health Sciences. Women's Studies Quarterly 10(2)1982:19-21.

Collins, Patricia Hill and Margaret Anderson (Eds.) An Inclusive Curriculum: Race, Class and Gender in Sociological Instruction. Available Fall, 1987 from the Teaching Resources Center, American Sociological Association, 1722 N St., N.W., Washington, D.C. 20036.

Cruikshank, Margaret (Ed.) Lesbian Studies: Present and Future. Old Westbury, NY: The Feminist Press, 1982.

Fritsche, JoAnn M. Toward Excellence and Equity: The Scholarship on Women as a Catalyst for Change in the University. Orono: The University of Maine Press, 1984.

Hull, Gloria T., Patricia Bell Scott and Barbara Smith (Eds.) But Some of Us Are Brave: Black Women's Studies. Old Westbury, NY: The Feminist Press, 1982.

McIntosh, Peggy. Interactive Phases of Curricular Re-Vision: A Feminist Perspective. Working Paper #124. Center for Research on Women. Wellesley College, Wellesley, MA 02181.

Multicultural Women's Studies: Special Issue [7 articles]. Radical Teacher #27(1984):1-27.

Rosser, Sue V. Teaching Science and Health from a Feminist Perspective: A Practical Guide. NY: Pergamon Press, 1986.

Schmitz, Betty. Integrating Women's Studies into the Curriculum: A Guide and Bibliography. Old Westbury, NY: The Feminist Press, 1985.

Schuster, M. and S. Van Dyne. Placing Women in the Liberal Arts: Stages of Curriculum Transformation. Harvard Educational Review 54(4)1984:413-428.

Smith, Beverly. Black Women's Health: Notes for a Course. In Gloria Hall, Patricia Bell Scott and Barbara Smith (Eds.) But Some of Us Were Brave: Black Women's Studies. Old Westbury, NY: The Feminist Press, 1982.

Teaching About Sex, Sexuality and Reproduction: Special Feature [8 articles and several syllabi]. Women's Studies Quarterly 12(4) Winter, 1984:2-35.

Teaching About Women, Race and Culture: Special Feature [20 articles and several syllabi]. Women's Studies Quarterly 14(1/2) Spring/Summer, 1986:2-58.

Teaching About Women and Violence: Special Feature [7 articles and several syllabi]. Women's Studies Quarterly 13(3/4) Fall/Winter, 1985:2-34.

Transforming The Traditional Curriculum: Special Feature [6 articles]. Women's Studies Quarterly X(1)Spring, 1982:19-34.

NURSING SCAN: WOMEN'S HEALTH--SUBSCRIPTION FORM

Nursing Scan:
Women's Health
College of Nursing
University of Illinois at Chicago
Women's Health Exchange
845 So. Damen Ave.
Chicago, IL 60612

Please enter my subscription to Nursing Scan: Women's Health, a quarterly current awareness document, for one year at 15.00.

My check made out to the University of Illinois is enclosed.

Name: ____
(Last) (First) (M.I.)

____

Address: ____
(Institution)

____
(Number) (Street)

____
(City) (State) (Zip)

WOMEN, HEALTH AND HEALING PROGRAM
DEPARTMENT OF SOCIAL AND BEHAVIORAL SCIENCES

NEW CURRICULAR MATERIALS IN WOMEN'S HEALTH

New bibliographies, syllabi and teaching materials are now available for graduate and undergraduate teaching and research in social science, health education and women's studies courses. Materials are appropriate for instruction in community colleges, universities and schools in the health professions.

MINORITY WOMEN, HEALTH AND HEALING IN THE U.S.: SELECTED BIBLIOGRAPHY & RESOURCES

A new bibliography on health issues of minority women, it includes sections on Black, Hispanic, Native American and Asian women. Topics include overviews, history, health status, health beliefs and behavior, utilization, policy, reproduction, sexuality, maternal and child health, mental health, minority women as providers of health care, comparative and reference works.

SYLLABI SET ON WOMEN, HEALTH AND HEALING: 15 COURSES

Syllabi emphasize social science perspectives on women's health. Courses include lower and upper division introductions and graduate instruction in health education, history, health policy, cross-cultural issues, social theory, poverty and women's health policy, quantitative research methods, older women's health, minority women's health and life cycle perspectives.

TEACHING MATERIALS ON WOMEN, HEALTH AND HEALING

Short articles focus on developing courses appropriate to varied institutions, integrating minority women's health issues into diverse curricula, teaching sensitive policy issues and pedagogical materials.

These curricular materials were developed by Virginia Olesen, Adele Clarke, and Patricia Anderson of UCSF with Sheryl Ruzek of Temple University. Support was provided by the Fund for the Improvement of Post-Secondary Education (DOE), the Department of Social and Behavioral Sciences, and the School of Nursing (UCSF).

DOCTORAL EDUCATION IN WOMEN, HEALTH AND HEALING AT UCSF

The Graduate Program in Sociology, UCSF, offers a track in women, health and healing for doctoral students. Information may be obtained from Susan Benner, Graduate Program in Sociology, Department of Social & Behavioral Sciences, School of Nursing, N-631-Y, University of California, San Francisco, CA 94143, (415) 476-3047.

UCSF

CURRICULAR MATERIALS IN WOMEN'S HEALTH

_____ Minority Bibliography $7.00
_____ Syllabi Set $10.00
_____ Teaching Materials $7.00
_____ Set of all three $20.00

All materials will be available by December 1, 1986. Payment must accompany order. Please make check payable to Women, Health and Healing Program and send to Women, Health and Healing Program, Department of Social and Behavioral Sciences, N-631-Y, UCSF, San Francisco, CA 94143-0612

Ship to: Name ______________________________ Phone # ______________
Address ____
____
____

_____ I would like information on the graduate program in Women, Health and Healing.
_____ I would like to be on the mailing list for Women, Health and Healing.

WOMEN
HEALTH
AND HEALING

CURRICULAR RESOURCES AND GRADUATE PROGRAM

Department of Social and Behavioral Sciences
School of Nursing
University of California, San Francisco

UCSF
University of California San Francisco
Women, Health and Healing Program
Department of Social and Behavioral Sciences
N-631-Y
San Francisco, California 94143